###### NEW PATIENT HISTORY FORM

**To our new patients:** To help us establish you with our Homeopathic practice, please provide us with your

complete health history including all Physical and Mental symptoms.

###  Date -\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Personal History

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_(mm/dd/yyyy) Age\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthplace\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_( City & Country )

Height\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_inches Weight\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_( lbs or Kg )

Referred by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Language for consultation –1st\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2nd\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_( English, Hindi, Urdu, Punjabi )

**ALLERGIES: Like – Food, Pollens, Odors, Medicines, Pets etc… \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Main problems/ reasons for this CONSULTATION:** (if possible, rank in terms of importance to you)

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional problems or concerns you would like to be addressed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*Note: we may not be able to address every problem during the course of one treatment.

# **Current Medications Dose Times / Day**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### Current Herbs / Vitamins/ Homeopathy/ Supplements Dose Times / Day

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

##### PAST MEDICAL, SURGICAL & TRAUMA HISTORY Patient Name:

List prior illness, injury, hospitalization, surgery, and/or trauma:

**Reason: Date/Month and Year**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **PERSONAL AND FAMILY HISTORY**

Check those that apply:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|   | Yourself | Mother | Father | Grandparents | Sister/ Brother | Spouse | Children |
| AIDS |  |  |  |  |  |  |  |
| Alcoholism |  |  |  |  |  |  |  |
| Allergies |  |  |  |  |  |  |  |
| Alzheimer’s |  |  |  |  |  |  |  |
| Anemia |  |  |  |  |  |  |  |
| Arthritis |  |  |  |  |  |  |  |
| Asthma |  |  |  |  |  |  |  |
| Birth Defects |  |  |  |  |  |  |  |
| Bleeding Disorder |  |  |  |  |  |  |  |
| Breast Cancer |  |  |  |  |  |  |  |
| Cancer |  |  |  |  |  |  |  |
| Colon Cancer |  |  |  |  |  |  |  |
| COPD |  |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |  |
| Emphysema |  |  |  |  |  |  |  |
| Epilepsy |  |  |  |  |  |  |  |
| Glaucoma |  |  |  |  |  |  |  |
| Heart Attack |  |  |  |  |  |  |  |
| Heart Trouble |  |  |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |  |  |
| IBS |  |  |  |  |  |  |  |
| Kidney Disease |  |  |  |  |  |  |  |
| Liver Disease |  |  |  |  |  |  |  |
| Mental Illness |  |  |  |  |  |  |  |
| Migraine Headaches |  |  |  |  |  |  |  |
| Pneumonia |  |  |  |  |  |  |  |
| Prostate Cancer |  |  |  |  |  |  |  |
| Sickle Cell Anemia |  |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |  |
| Suicide |  |  |  |  |  |  |  |
| Tuberculosis |  |  |  |  |  |  |  |
| Ulcers |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |

**SOCIAL HISTORY (**check those that apply): **Patient Name:**

**Marital status: Education level completed: Memories of your childhood Do You Find Your Life**

[ ]  single [ ]  high school [ ]  Mostly happy [ ]  Generally Unsatisfactory

[ ]  married [ ]  college [ ]  Mostly painful [ ]  Too Demanding

[ ]  divorced [ ]  professional school [ ]  Normal [ ]  Boring

[ ]  Widowed [ ]  other: [ ]  don’t recall [ ]  Satisfactory

**Living arrangement:**

[ ]  alone [ ]  family [ ]  roommate [ ]  significant other

[ ]  children (list sex/ages):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Major stresses in last 2 years [ ]  Money [ ]  Job [ ]  Marriage [ ]  Home Life [ ]  Children

[ ]  other stress\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pertinent travel history:**(out of USA, epidemic areas)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIFESTYLE / SELF-CARE ISSUES**

Do you smoke cigarettes? [ ]  YES [ ]  NO If yes, how many? #\_\_\_\_\_yrs. \_\_\_\_\_\_\_\_\_\_\_\_\_\_ packs per day

Did you ever smoke? [ ]  YES [ ]  NO If yes, when did you quit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? [ ]  YES [ ]  NO If yes, how much? Type\_\_\_\_\_\_\_\_\_ & \_\_\_\_\_\_\_\_\_ drinks per week

Do you drink caffeine beverages? [ ]  YES [ ]  NO If yes, which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use recreational drugs? [ ]  YES [ ]  NO If yes, which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you manage stress well? [ ]  YES [ ]  NO [ ]  NOT SURE [ ]  NEED HELP

Do you exercise regularly? [ ]  YES [ ]  NO If no, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you enjoy your job? [ ]  YES [ ]  NO If no, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you allow time to unwind and relax? [ ]  YES [ ]  NO If no, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you sleep soundly? [ ]  YES [ ]  NO If no, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you satisfied with your sex life? [ ]  YES [ ]  NO If no, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you satisfied with your social life? [ ]  YES [ ]  NO If no, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you satisfied with your spiritual life? [ ]  YES [ ]  NO If no, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your diet healthy enough? [ ]  YES [ ]  NO [ ]  NOT SURE [ ]  NEED HELP

Typical breakfast\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Typical lunch \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Typical dinner\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Typical snacks\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Devices

**Do You Use:**

\_\_\_Eyeglasses \_\_\_\_\_\_Contact Lens \_\_\_\_\_\_Hearing Aid \_\_\_\_\_\_Dentures

\_\_\_Brace (Neck, Back) \_\_\_\_\_\_ Pacemaker \_\_\_\_\_\_ IUD, Diaphragm \_\_\_\_\_\_Artificial Limbs

## REVIEW OF SYSTEMS Patient Name:

Check any symptoms that currently apply to you:

Constitutional Mouth, Throat Muscles, Bones & Joints Digestion & Intestines

\_\_\_ poor appetite \_\_\_ tongue discoloration \_\_\_\_neck pain \_\_\_\_indigestion

\_\_\_ fevers \_\_\_ bad breath \_\_\_\_back pain \_\_\_\_belching/ flatulence

\_\_\_ chills \_\_\_ teeth problems \_\_\_\_muscle pain \_\_\_\_difficulty swallowing

\_\_\_ food craving \_\_\_ grinding teeth \_\_\_\_ painful joints: R\_\_L\_\_ \_\_\_\_heartburn/ ulcer

\_\_\_ weight loss \_\_\_ tonsillitis/ adenoids \_\_\_\_shoulder \_\_\_\_elbow \_\_\_\_nausea

\_\_\_ weight gain \_\_\_ facial pain \_\_\_\_hip\_\_\_\_ knee \_\_\_ankle \_\_\_\_ liver trouble

\_\_\_ fatigue \_\_\_ sore throat \_\_\_\_wrist \_\_\_\_\_fingers \_\_\_\_ vomiting

**Eyes** \_\_\_ ulceration tongue \_\_\_\_joint swelling \_\_\_\_ diarrhea

\_\_\_ eye pain \_\_\_ gum bleeding \_\_\_\_muscle weakness \_\_\_\_ cramping bowels

\_\_\_ blurred vision **Heart & Circulation \_\_\_\_**muscle cramps \_\_\_\_ food allergies

\_\_\_ poor vision\_\_\_day \_\_\_\_chest pain **Skin, Hair \_\_\_\_**constipation

\_\_\_ poor vision\_\_\_night \_\_\_\_ lightheadedness \_\_\_\_ psoriasis \_\_\_\_ abdominal pain

\_\_\_ wear corrective lenses \_\_\_ palpitations \_\_\_\_ warts \_\_\_\_rectal pain/ itching

\_\_\_ near\_\_\_\_far sighted \_\_\_\_ cold hands/feet \_\_\_\_ freckles \_\_\_\_ hemorrhoids/ piles

\_\_\_ other \_\_\_\_ fainting \_\_\_\_ itching, hives \_\_\_\_ blood in stool

### Ears, Nose \_\_\_\_ swelling feet \_\_\_\_ hair loss Urine, Kidney, Bladder

\_\_\_ ringing ears \_\_\_\_ blood clots \_\_\_\_ dry skin, eczema \_\_\_\_painful urination

\_\_\_ nosebleed/polyp \_\_\_\_ varicose veins **Nerves, Movement, Brain \_\_\_\_**wake up to urinate

\_\_\_postnasal drip **Breathing & Lungs \_\_\_\_** seizures **\_\_\_\_**kidney stones

\_\_\_sinus problems \_\_\_\_\_shortness of breath \_\_\_\_\_nerve pain \_\_\_\_ loss of control

\_\_\_trouble with taste/smell \_\_\_\_\_wheezing or asthma \_\_\_\_\_poor balance \_\_\_\_ frequent urination

\_\_\_poor hearing \_\_\_\_\_repeated colds/ flu \_\_\_\_\_poor coordination \_\_\_\_ sudden urging

\_\_\_earaches/ infections \_\_\_\_\_ cough dry/ irritating \_\_\_\_\_tremors or shaking \_\_\_\_ blood/pus urine

\_\_\_sneezing/ discharges \_\_\_\_\_headaches \_\_\_\_urine infection UTI

### Immune System Sexual Organs Women Reproductive

**\_\_\_\_**too many infections \_\_\_\_ sores on genitals \_\_\_\_\_ pelvic pain \_\_\_\_age period started

\_\_\_\_allergies to food \_\_\_\_ lumps or swelling \_\_\_\_\_ vaginal discharge \_\_\_\_ # of pregnancies

\_\_\_\_allergies to environment \_\_\_\_ erection problems \_\_\_\_\_ painful periods \_\_\_\_# abortions

 \_\_\_ other concerns \_\_\_\_ premature ejaculation \_\_\_\_\_premenstrual syndrome \_\_\_\_# miscarriages

### Blood System \_\_\_\_pain with sex \_\_\_\_\_ hot flashes \_\_\_\_# live births

\_\_\_\_lymph gland swelling \_\_\_\_infertility \_\_\_\_\_ itching or soreness \_\_\_children currently living

\_\_\_\_anemia \_\_\_\_repeated infections \_\_\_\_\_irregular menses \_\_\_age menopause \_\_\_ \_\_\_\_easy bruising \_\_\_\_aversion to sex \_\_\_\_\_leucorrhoea \_\_\_past infertility

Mind Symptoms Thermal State

\_\_\_\_memory \_\_\_hot

\_\_\_\_temper/anger \_\_\_chilly

\_\_\_\_emotional

\_\_\_\_sleep

**Additional Symptoms** --\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **IF NOT NOTED IT IS EITHER NEGATIVE, NON-CONTRIBUTORY, AND/ OR NON-PERTINENT.**

## HEALTH SCREENING HISTORY Patient Name:

List the date of your most recent test or exam.

Mammogram \_\_\_\_\_\_\_\_\_ Pap Smear\_\_\_\_\_\_\_\_\_\_ Self Breast Exam \_\_\_\_\_\_\_\_\_\_\_Breast Exam by Doctor\_\_\_\_\_\_\_\_\_\_\_\_

Blood test for Cholesterol \_\_\_\_\_\_\_\_\_ Blood Sugar \_\_\_\_\_\_\_\_Other Blood tests\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Immunizations: Tetanus\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Hepatitis\_\_\_\_\_\_\_\_\_\_\_\_\_\_MMR\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Flu Shot\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Test for Blood in stool\_\_\_\_\_\_\_ Rectal Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_Feeling the Prostate\_\_\_\_\_\_\_\_\_ Scope Lower Bowel\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Self Exam Testicle \_\_\_\_\_\_\_\_\_\_\_Testicle Exam by Professional\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Anatomy\Procedure | X-ray | MRI | CT Scan | Ultrasound | Bone Scan | EKG | EEG |
| Back |  |  |  |  |  |  |  |
| Brain |  |  |  |  |  |  |  |
| Chest |  |  |  |  |  |  |  |
| Colon |  |  |  |  |  |  |  |
| Extremities (Arm/ Leg) |  |  |  |  |  |  |  |
| Gallbladder |  |  |  |  |  |  |  |
| Kidney |  |  |  |  |  |  |  |
| Neck |  |  |  |  |  |  |  |
| Pelvis |  |  |  |  |  |  |  |
| Stomach |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |

>>Copies of reports should be sent with the patient form

 Mailing Address -- PAL

**>>Pictures should be sent with the patient form 14534 GRAHAM AVE**

 **VICTORVILLE, CA**

 **USA 92394**

 **This history record has been designed to facilitate our patients to assess their health issues in detail.**

 **Once Homeopath Pal Looks over this history record and reports he will be asking you specific questions pertaining to your symptoms to get a complete disease picture*. Each symptom will be completed regarding its location, extension, sensation, modalities and concomitants during* the virtual consultation process.**

 **A complete case record thus created will be analyzed for a Homeopathic prescription. This is a confidential record and will be kept in the office. Information contained here will not be released to anyone without your authorization to do so.**

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**Date Patient/ Guardian signature that filled out the history**

**Mailing Address Phone – Home -- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Cell -- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Email -- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**For more information visit** [**www.homeopathyphysician.com**](http://www.homeopathyphysician.com) **see virtual consultation tutorial**