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HEALTH HISTORY

Welcome! Please take your time and fill this form out as completely as you can. It will greatly assist Christina with finding the correct homeopathic remedy for you. All responses are held in absolute confidence.

Patient name _____ Date filled out _____

Age _____ Date of birth _____ Gender *(circle one)* M F

If a minor, name of parents or guardians _____

Street address _____

City _____ State _____ Zip code _____

Home phone _____ Work phone _____ Cell phone _____

Email _____ Would you like to be on our email list? *(circle one)* Yes No

How do you wish to be contacted? *(circle one)* Home phone Work phone Cell phone Email

Please tell us who referred you. _____

Please describe complaints you would like assistance with in order of importance (top is most important).

Complaint	When did it start?	Cause

What other health care professionals are you under the care of?

Name	Location	Phone

HEALTH HISTORY

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What surgeries have you had?

Surgery	Reason for surgery	When it was	Any complications

What major injuries have you had?

Nature of the injury	When it occurred	Any long term effects

What medications and supplements are you currently taking?

Medication name	Dose	Date begun	Any adverse effects

Which of the following conditions have you had? *(please circle all that apply)*

Abscesses	Digestive problems	Heart disease	Parkinson's disease	Styes
Acne	Ear infections	Hepatitis	Pelvic inflammatory disease	Stroke
Alcoholism	Eczema	Infertility	Plantars fasciitis	Sun stroke
Allergies	Endometriosis	Ingrown toenails	Pleurisy	Thyroid problem
Anemia	Epilepsy	Joint pain	Pneumonia	Tonsillitis
Asthma	Fatigue	Kidney disease	Psoriasis	Tropical disease
Athletes foot	Fibromyalgia	Menopause	Respiratory disease	Tuberculosis
Back pain	Flu (frequent)	Menstrual problems	Rheumatic fever	Uterine fibroid
Cancer	Gall stones	Miscarriage	Root canal	Vaginitis
Chicken pox	Genital herpes	Mononucleosis	Scarlet fever	Venereal disease
Colds (frequent)	Goiter	Mood problems	Sexual abuse	Venereal warts
Cold sores	Gout	Multiple sclerosis	Sinusitis	Warts
Depression	Hay fever	Mumps	Skin disease	Whooping cough
Diabetes	Headaches	Parasites		Worms

HEALTH HISTORY

Are there other major conditions you've had that were not mentioned on the previous page? _____

_____

_____

Have you never completely recovered from any of these conditions? _____

_____

_____

When was your last physical exam? _____

Any adverse effects from vaccinations? *(describe)* _____

_____

Have you ever taken antibiotics for a prolonged period of time? *(circle one)* Yes No

For what condition? _____

Have you lost weight over the past 12 months? *(circle one)* Yes No How many pounds? _____

Gained weight? *(circle one)* Yes No How many pounds? _____

Describe the exercise you do and frequency. _____

_____

How much of the following substances are you using?

Tobacco _____ Coffee _____ Tea _____ Alcohol _____

Recreational drugs _____

Any known allergies to food, drugs or environment? _____

_____

For Men Only PSA count _____

For Women Only Age of first menses _____

Number of pregnancies _____ Number of miscarriages _____ Number of abortions _____

General Family History Which of the following have affected your relatives? *(circle all)*

Alcoholism	Arthritis	Depression	Epilepsy	Hay fever	Paralysis	Syphilis
Allergies	Asthma	Diabetes	Gonorrhea	Heart disease	Pneumonia	Tuberculosis
	Cancer		Gout		Skin disease	

Please provide relatives' current age or age at death and their ailments.

	Age if alive	Age at death	Ailments
Mother			
Father			
Sisters			
Brothers			
Maternal grandmother			
Maternal grandfather			
Maternal aunts/uncles			
Paternal grandmother			
Paternal grandfather			
Paternal aunts/uncles