Restoring to Health With Homeopathy
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Health History

Name _____ **Date** _____ **Birth date** _____

Date of last physical exam _____ What is your reason for today's visit? _____

Symptoms check (✓) symptoms you currently have or have had in the past year.

General
- ❑ Chills
- ❑ Depression
- ❑ Dizziness
- ❑ Fainting
- ❑ Fever
- ❑ Forgetfulness
- ❑ Headache
- ❑ Loss of sleep
- ❑ Loss of weight
- ❑ Nervousness or anxiety
- ❑ Numbness
- ❑ Sweats

Muscle/Joint/Bone
Pain, weakness or numbness in:
- ❑ Arms ❑ Hips
- ❑ Hands ❑ Feet
- ❑ Back ❑ Legs
- ❑ Neck ❑ Shoulders

Genitourinary
- ❑ Blood in urine
- ❑ Frequent urination
- ❑ Lack of bladder control
- ❑ Painful urination

Gastrointestinal
- ❑ Appetite poor
- ❑ Bowel changes
- ❑ Constipation
- ❑ Diarrhea
- ❑ Excessive hunger
- ❑ Excessive thirst
- ❑ Gas
- ❑ Hemorrhoids
- ❑ Indigestion
- ❑ Nausea
- ❑ Rectal bleeding
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Vomiting blood

Cardiovascular
- ❑ Chest pain
- ❑ High blood pressure
- ❑ Irregular heart beat
- ❑ Low blood pressure
- ❑ Poor circulation
- ❑ Rapid heart beat
- ❑ Swelling of ankles
- ❑ Varicose veins

Eye, Ear, Nose, Throat
- ❑ Bleeding gums
- ❑ Blurred vision
- ❑ Cold sores
- ❑ Crossed eyes
- ❑ Difficulty swallowing
- ❑ Double vision
- ❑ Earache
- ❑ Ear Discharge
- ❑ Hay fever
- ❑ Hoarseness
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Persistent cough
- ❑ Photophobia
- ❑ Ringing in ears
- ❑ Sinus problems
- ❑ Eye infections
- ❑ Vision—flashes
- ❑ Vision—halos

Skin
- ❑ Bruise easily
- ❑ Eczema
- ❑ Hives
- ❑ Itching
- ❑ Change in moles
- ❑ Psoriasis
- ❑ Rash
- ❑ Scars
- ❑ Sore that won't heal

Men only
- ❑ Breast lump
- ❑ Erection difficulties
- ❑ Lump in testicles
- ❑ Penis discharge/sores
- ❑ Other

Women only
- ❑ Abnormal Pap smear
- ❑ Bleeding between periods
- ❑ Breast lump
- ❑ Extreme menstrual pain
- ❑ Hot flashes
- ❑ Nipple discharge
- ❑ Painful intercourse
- ❑ Vaginal discharge
- ❑ Other

Date of last menstrual period?_____

Date of last Pap smear?_____

Have you had a mammogram?
☐ No ☐ Yes

Are you pregnant? ☐ No ☐ Yes

What form of birth control do you use?_____

Number of pregnancies? _____

Number of children__ _____ __

Conditions check (✓) those you have or have had in the past
- ❑ AIDS/HIV
- ❑ Alcoholism
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding disorders
- ❑ Breast lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical dependency
- ❑ Chickenpox
- ❑ Colitis
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herpes
- ❑ High cholesterol
- ❑ Irritable Bowel Disease
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Measles
- ❑ Migraine headaches
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Pacemaker
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate problem
- ❑ Psychiatric care
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Stroke
- ❑ Suicide attempt
- ❑ Thyroid problems
- ❑ TMJ
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal infections
- ❑ Sexually transmitted illness
- ❑ Whooping cough

Medications and Supplements. List those you are currently taking.	**Allergies** to medications and substances.

Family History

Relation	Age	State of Health	Age at Death	Cause of Death
Father				2
Mother				
Brothers				
Sisters				

Check (✓) if your **blood relatives** had any of the following and describe their relationship to you

- ☒ Aneurysm 2
- ☐ Anxiety_____
- ☐ Arthritis/Gout_____
- ☐ Asthma_____
- ☐ Autism_____
- ☐ Bipolar Disorder_____
- ☐ Brain Tumors_____
- ☐ Cancer_____
- ☐ Cerebral Palsy_____
- ☐ Chemical dependency_____
- ☐ Depression_____
- ☐ Epilepsy/Seizures_____
- ☐ Gonorrhea_____
- ☐ Headaches/Migraines _____
- ☐ Heart disease_____
- ☐ High blood pressure_____
- ☐ Kidney disease_____
- ☐ Learning disabilities_____
- ☐ Mental retardation_____
- ☐ Muscular disease _____
- ☐ Obsessive Compulsive DO_____
- ☐ Schizophrenia_____
- ☐ Syphilis_____
- ☐ Tics_____
- ☐ Tuberculosis_____

Health Habits check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Alcohol	
	Drugs	
	Other	

Occupational Concerns check (✓) if your work exposes you to the following:

	Stress
	Hazardous substances
	Heavy lifting
	Other

Exercise. What kind of exercise do you do, and how often? _____

Serious Illness/Injuries and Hospitalizations	Date	Outcome	Pregnancy History Year/Date of birth	Complications if any

Preferences, Habits, and Particulars

Food

Which foods do you crave?

☐Sweet ☐Sour ☐Salty ☐Fats ☐Breads

Which foods do you hate? _____

Appetite? ☐Good ☐Fair ☐Poor

Thirst? ☐Very thirsty ☐Medium ☐Not at all

Sleep Habits

Bed time? _____

Wake time? _____

Time to fall asleep? _____

Sleep position? _____

Do you recall your dreams? ☐Yes ☐No

During sleep do you:

☐Grind teeth ☐Snore

☐Perspire ☐Walk

☐Talk ☐Have nightmares?

☐Wake at night? Time_____

Fears

☐Claustrophobia ☐Dark

☐Heights ☐Flying

☐Thunder/Lightning ☐Water

☐Animals. Which ones? _____☐Other_____

Temperature

Sense of body temperature? ☐Chilly ☐Warm ☐Neutral

Hands? ☐Chilly ☐Warm ☐Neutral

Feet? ☐Chilly ☐Warm ☐Neutral

Other

Do you bite your nails? ☐Yes ☐No

Do you grind your teeth? ☐Yes ☐No

Best time of day? _____ Worst time of day? _____

Favorite book or movie?

Reviewed with patient_____