

Name: Date of Birth:

List Current Health Concern(s):
.....
.....
.....
.....

Have you seen an MD for your current problem(s)?
.....

Have you seen or do you see any other 'alternative' practitioners for your current or past conditions?
.....

If yes, type and name of practitioner(s):
.....

Have you taken homeopathic remedies before?
.....

MEDICAL HISTORY (*please be brief*)

Past Major Illnesses:
.....
.....

Past Hospitalizations:
.....

Adverse reactions to medications, vaccines etc.:
.....

MEDICATIONS (*list medications*)

Current:
.....

Past:
.....

Vitamins and other natural therapies:
.....

Do you smoke? How much? How long?
.....

Health of your mother when she was pregnant with you (if known):

Did she suffer from vomiting anemia toxemia emotional trauma
.....
high blood pressure any other problems
.....

Was your birth:

Normal long difficult breech forceps
.....
Premature Cesarean
.....

Were you breastfed? Yes/No/Don't know. If yes, how long for?
.....

Did you cry a lot? If so why?
.....

At what age did you teethe crawl walk talk
.....

Childhood illnesses:

Did you suffer from recurring:

Coughs/chest infections:
.....

Ear infections:
.....

Tonsillitis/throat infections:
.....

Stomach aches:
.....

Any other illnesses:
.....

FAMILY HISTORY:

Mother: Age General health
.....

Health problems (*in childhood and as an adult*):
.....
.....

Father: Age General health
.....

Health problems (*in childhood and as an adult*):
.....
.....

Immediate family history: Brothers/Sisters/Grandparents etc. (*general health, including major illnesses and those preceding death if appropriate*):

Siblings:

.....

Maternal Grandparents:

.....

.....

Paternal Grandparents:

.....

.....

Your Children:

.....