MEDICAL BACKGROUND FORM—Adelaide Homoeopathic Clinic—Confidential

PERSONAL HISTORY

Name ..... D.O.B.....

Address: …… Postcode:……

Contact numbers: Home:……. Work:……..

Mobile:…….. Email:……

Marital Status:……...

Children: (list names and current ages) ……

……..

PRESENTING COMPLAINTS: (what you would like me to help you with) ……..

……..

ADDICTIONS: ……...

ALLERGIES: …….

……...

FEARS: …….

……

ENVIRONMENT:
Do you prefer to be Outdoors or Inside? …….Do you need to sleep with a window open? Y/N

Which season to you prefer Summer/ Winter/ Autumn/ Spring. Why? ……...

Does a particular type of weather affect you? ……..

APPETITE: poor/ fair/ good/ very good (please circle whichever is applicable)

Food desires: …….

Food aversions: …….

Food that disagrees: (upset stomach/bowel etc)……

THIRST: slight/ average/ very thirsty

What do you desire to drink most often …….

What other beverages do you drink ……..

BOWELS/RECTUM:
Do you suffer from Constipation/ Diarrhoea/ Irritable Bowel Syndrome/ Hemorrhoids (circle as many as applicable)

Do you have any problems with pain/flatulence?

KIDNEYS/URINE:
Have you had any kidney infections/ urinary tract infections etc

SKIN:
Have you had any skin problems throughout your life? Eczema, dermatitis, acne etc. ……

…….

……

REPRODUCTION:

Female -

Age of first menses approx …….. Did you go into a regular cycle? ……

Length of cycle ……. Length of bleed……. PMT/Mood swings …….

Period pain—Yes/No How many days before period: …… How long did it last? ……...

What eased the pain?.....

What have you used for contraception throughout your adult life? ……..

……..

Give details of current menses or menopause ……..……

……..

MALE/FEMALE:

Have you suffer or have you suffered from any STD/herpes infections? Yes/No

Libido currently: poor/ average/ good/ very good

Libido in the past: poor/ average/ good/ very good

Do you have any pain on intercourse Yes/No

Do you have any vaginal/penis discharge ?
Yes/No Colour……..... Consistency …… Itching/Burning……..

EMOTIONS:
How would you describe your self on an emotional level: ……

List your favorite things you enjoy: ……..

……

List the things you most dislike: ……..

……

MEMORY: How would you rate your memory at the moment—awful/ poor/ average/ good/ great

SLEEP: poor/good/great What is your normal sleeping position?.....

Difficulty getting off to sleep? Yes/No Wake at a certain time each night? …….

Are you a light or heavy sleeper? …… Do you wake refreshed? ……..

DREAMS:
Recurrent Yes/No Similar themes?..... Wake you with fright ……..

PRE-NATAL INFORMATION:
Please state (if known) the health of your mother when she was pregnant with you.....

Did she suffer from vomiting ..... anemia ..... toxemia ..... emotional trauma .....

high blood pressure ..... any other problems .....

Was your own birth:

normal ..... long ..... difficult ..... breech ..... forceps ..... premature ..... Cesarean .....

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

Were you a 'good' baby? Yes/No/Don't know. Did you cry a lot? ..... If so, why? .....

At what ages did you teeth ..... crawl ..... walk ..... talk .....?

CHILDHOOD ILLNESSES

Please give approx ages at which you had the following illnesses and indicate if they were severe or long-lasting:

Chicken pox ..... Mumps .....

German Measles ..... Scarlet Fever .....

Measles ..... Whooping Cough .....

Did you suffer from recurring:

Coughs/chest infections .....

Ear infections .....

Tonsillitis/throat infections .....

Stomach aches .....

Any other illnesses:

VACCINATIONS

Please give ages (or dates) of vaccinations and indicate if there was a bad reaction:

Polio ..... Influenza .....

Diphtheria ..... BCG (TB) .....

Tetanus ..... Smallpox .....

Whooping Cough ..... Typhoid .....

Measles ..... Yellow Fever .....

Rubella ..... Cholera .....

MMR ..... Gamma globulin .....

Chicken pox ..... Hepatitis B .....

HIB .....

Any other vaccinations:

OPERATIONS

Please give brief details of all operations to date:

ACCIDENTS

Please give details of any serious falls/burns/broken bones/injuries etc.:

FEVER/SWEAT: (location, smell, texture etc.)

X-RAYS
Please add up (roughly) the number of x-rays you have had:

Dental: Other:

MEDICATION
On a separate sheet of paper (or on the back of this one) please list all medications (including herbal, homeopathic and vitamin/mineral supplements) that you are currently taking. Also a list of all homeopathic remedies and the major orthodox medications you have taken up to date.

FAMILY HISTORY

MOTHER: Date of birth: Occupation:

Overall health:

Specific problems (in childhood and as an adult):

FATHER: Date of birth: Occupation:

Overall health

Specific problems (in childhood and as an adult):

IMMEDIATE FAMILY HISTORY: BROTHERS/SISTERS/GRANDPARENTS ETC.
Please give as much information as is known regarding the overall health, including major illnesses (especially those preceding death if appropriate) of each sibling, grandparent—and great-grandparents if possible.

Grandparents:
Maternal Side -

Paternal Side -

Brothers:

Sisters:

Uncles/ Aunts:

Please check below if you know (or can find out) if any of the following have occurred in your immediate family:

ALCOHOLISM ..... ARTHRITIS/RHEUMATISM/GOUT ..... ASTHMA .....

CANCER ..... DIABETES ..... ECZEMA ..... EPILEPSY .....

HAY FEVER ..... HEART PROBLEMS - high blood pressure/angina/strokes etc. .....

HERNIA/VARICOSE VEINS ..... HERPES (oral/genital) ..... WARTS .....

JAUNDICE/HEPATITIS ..... VENEREAL DISEASES ..... TUBERCULOSIS .....

MENTAL ILLNESS (including suicides) ..... SKIN PROBLEMS .....

Other illnesses not listed above: