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**HOMEOPATHIC PATIENT QUESTIONNAIRE**

<b>First name:</b>	<b>Last name:</b>
<b>Date of birth: / /</b>	<b>Today's date:</b>
<b>Address:</b>	<b>Sex (Circle):    Male    Female</b>
<b>City:</b>	<b>Height:                      Weight:</b>
<b>ZIP:</b>	
<b>Home telephone:</b>	<b>Work Telephone:</b>
<b>Cell phone/pager:</b>	<b>Website:</b>
<b>Emergency contact: (Name, relationship, Address, Tel)</b>	
<b>Email address:</b>	<b>Occupation:</b>
<b>Religion:</b>	<b>Contact details for primary doctor:</b>
<b>MARITAL STATUS (Circle)</b>	
<b>Single, Married, Gay, Divorced, Separated, Widowed, Domestic partnership</b>	

How did you find out about me? \_\_\_\_\_  
 \_\_\_\_\_

Thank you for taking the time to fill out this questionnaire.  
 It designed to help me to understand your problem and to understand you as a person.  
 It is also aimed at giving you a greater awareness of your symptoms,  
 making it easier to relay them to me during our consultation.

Looking forward to meeting you.

**Please type or write neatly.**  
**You may fax, hand deliver, mail or email this questionnaire**  
**to the clinic, or bring it along with you to your visit.**

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**THIS REPORT WILL BE TREATED AS STRICTLY CONFIDENTIAL**



**Section B: MEDICAL HISTORY**

List any medication/ vitamins/ herbs or supplements you are currently taking:

<b>DRUG</b>	<b>DOSAGE</b>	<b>INDICATION</b>

*Don't forget to bring along any relevant medical records you have available.*

List medicines you have taken frequently in the past or over an extended period of time.

<b>DRUG</b>	<b>DOSAGE</b>	<b>INDICATION</b>

List any surgeries you have had:

<b>DATE</b>	<b>SURGICAL PROCEDURE</b>	<b>REASON</b>

What childhood illness/injuries did you have?

<b>AGE</b>	<b>ILLNESS/ INJURY</b>	<b>REACTION TO ILLNESS e.g. frequency, reoccurrences, severe, hospitalized, mild</b>
<b>AGE</b>	<b>CHILDHOOD ILLNESSES</b>	<b>REACTION TO ILLNESS e.g reoccurrences, frequency, severe, mild hospitalization, etc</b>

Have you had any of the following **illnesses**? Check all that apply:

- Mumps<sup>1</sup> Measles<sup>1</sup> Chicken-pox<sup>1</sup> Polio<sup>1</sup> Glandular fever<sup>1</sup> Mononucleosis<sup>1</sup> Pneumonia<sup>1</sup>  
 Eczema<sup>1</sup> Asthma<sup>1</sup> Tuberculosis<sup>1</sup> Cancer<sup>1</sup> Gonorrhoea<sup>1</sup>

Name: \_\_\_\_\_

Which **vaccinations** have you had? Check all that apply:

Small pox  Polio  Mumps  Measles  Chicken pox  Tetanus  Hepatitis  Flu  Other

Have you had any vaccinations in the last year? Yes  No  If Yes, describe:

Have you ever had any reactions to vaccination? Yes  No  If Yes, describe

**Section C: FAMILY HISTORY**

Please fill in the details of your family's medical history. If you are adopted and do not know your family's history please indicate so and leave out this section. Please fill in this section as best as you can. Many of you will not know all the details, and that is fine too.

	Age	History of illness, current state of health	Age of death	Cause of death
<b>Father</b>				
<b>Mother</b>				
<b>Brothers</b>				
<b>Sisters</b>				
<b>Paternal Grandmother</b>				
<b>Paternal Grandfather</b>				
<b>Maternal Grandmother</b>				
<b>Maternal Grandfather</b>				

Are there any illnesses that run in your family? \_\_\_\_\_

Is there any family history of: Please check: Tuberculosis  Cancer  Gonorrhoea  Scabies

Name: \_\_\_\_\_

**Section D: DIET & LIFESTYLE**

This is to find out what you typically eat during the day. Please answer this section as honestly as possible.

**BREAKFAST:**

Time: \_\_\_\_\_  
Eat what: \_\_\_\_\_

Snack: \_\_\_\_\_

**LUNCH:**

Time: \_\_\_\_\_  
Eat what: \_\_\_\_\_

Snack: \_\_\_\_\_

**SUPPER:**

Time: \_\_\_\_\_  
Eat what: \_\_\_\_\_

Before bed: \_\_\_\_\_

Do you wake up at night to eat/ drink? Yes  No  Please describe: \_\_\_\_\_

Any foods that you strongly **desire**? \_\_\_\_\_

Any foods that you strongly **dislike**? \_\_\_\_\_

Any foods that make you ill? \_\_\_\_\_

If yes, what symptoms do you experience? \_\_\_\_\_

Which of the following tastes do you desire the most? Check all that apply:

Sweet  Salty  Sour  Spicy  Pungent  Pickles  Bitter

**Smoking:**

Please check that which applies to you. Are you a:

**Non-smoker**  **Quit smoking**  How long ago? \_\_\_\_\_ **Smoker**  How many a day? \_\_\_\_\_

**Drinking habits:**

How much alcohol do you consume a week? \_\_\_\_\_

What alcohol do you drink? \_\_\_\_\_

**Drug use:**

Which recreational drugs have you used in the past? \_\_\_\_\_

Which recreational drugs do you currently use? \_\_\_\_\_

How often do use recreational drugs? \_\_\_\_\_

**Exercise:**

Do you currently participate in any form of exercise? Yes  No

If yes, what exercise and how often? \_\_\_\_\_

What do you enjoy doing for relaxation? \_\_\_\_\_

## **Section E: General symptoms**

Please **CHECK** the information that applies to you:

- 1) Are you? Thirsty  Thirstless  Some where in between
- 2) What do you drink? \_\_\_\_\_
- 3) Do you? Sip drinks slowly  Gulp drinks down  Neither
- 4) Do you prefer drinks that are? ice cold  hot drinks  room temperature
- 5) Is your appetite? Ravenous  Average  Small  Increased  Decreased
- 6) Is your body temperature? Too hot  Too cold   
Can't stand heat /cold  Not significant
- 7) What weather are you best in? \_\_\_\_\_
- 8) Is there any weather that aggravates you? \_\_\_\_\_
- 9) Is your perspiration? Extreme  Profuse  Average  Slight  Not at all
- 10) Where do you perspire from? \_\_\_\_\_
- 11) Please describe the odor of your perspiration as best as you can? E.g. sweet, metallic, musty, foul, etc \_\_\_\_\_
- 12) Does it stain your clothes? No  Yes  If yes, what color? \_\_\_\_\_
- 13) What is your energy level like? Hyperactive  Good energy  OK energy  No energy
- 14) When is your energy best? \_\_\_\_\_
- 15) When is your energy at its worst? \_\_\_\_\_
- 16) Do you suffer from? (Check all that apply) Constipation  Diarrhea  Hemorrhoids   
Gas  Bloating
- 17) Do you have any pain on urinating? Yes  No
- 18) Do you suffer from urinary tract infections? Yes  No
- 19) Does your urine have a strong odor? Yes  No  If yes, please describe \_\_\_\_\_

## **Section F: Skin & Nails**

- 1) Check any skin conditions you have now or have had in the past?  
Eczema  Psoriasis  Warts  Skin tags  Cradle cap  Athlete's foot  Ringworm   
Scabies  Impetigo  Acne  Acne rosacea  Hives  Other   
Describe these skin complaint(s) in detail, noting whether you suffer from it now or previously, as an adult or a child and the treatment(s) you've used?  
\_\_\_\_\_  
\_\_\_\_\_
- 2) Describe your fingernails: Cracked  Peel  White spots  Fungus  Discolored  Ridged
- 3) Describe your toe nails: Cracked  Peel  White spots  Fungus  Discolored  Ridged
- 4) Do you? Bite your nails  Peel your nails

## **Section G: Sleep**

- 1) How do you rate your sleep? Good  Fair  Average  Poor  Terrible
- 2) Do you have difficulty falling asleep at night? Yes  No
- 3) Do you wake up in the middle of the night? Yes  No  If yes, at what time(s)? \_\_\_\_\_
- 4) Do you have difficulty falling asleep again? Yes  No
- 5) Do you wake up feeling refreshed in the morning? Yes  No

- 6) In what position do you sleep at night? \_\_\_\_\_
- 7) Do you do any of the following? Sleep walk<sup>1</sup>    Sleep talk<sup>1</sup>    Grind your teeth<sup>1</sup>    Snore<sup>1</sup>
- 8) Are nightmares a problem for you? Yes<sup>1</sup>    No<sup>1</sup>

### **Section H: FOR WOMEN to complete**

- 1) At what age did your periods begin? \_\_\_\_\_
- 2) Your periods are? (Check all that apply) Regular<sup>1</sup>    Irregular<sup>1</sup>    Too early<sup>1</sup>    Too late<sup>1</sup>  
Light flow<sup>1</sup>    Medium flow<sup>1</sup>    Heavy flow<sup>1</sup>
- 3) Describe the blood: (Check all that apply) Bright red<sup>1</sup>    Dark red<sup>1</sup>    Pale<sup>1</sup>    Pink<sup>1</sup>    Clotted<sup>1</sup>  
Stringy<sup>1</sup>    Membranous<sup>1</sup>
- 4) Do you have any pain associated with your period? Yes<sup>1</sup>    No<sup>1</sup>    If Yes, describe the pain:  
\_\_\_\_\_  
Does it occur: (Check all that apply) Before<sup>1</sup>    During<sup>1</sup>    After menstruation<sup>1</sup>
- 5) Do you experience any physical, emotional or behavioral changes before, during or after your periods? Yes<sup>1</sup>    No<sup>1</sup>    If Yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 6) Describe any symptoms during ovulation: \_\_\_\_\_
- 7) What type of contraception do you use? \_\_\_\_\_
- 8) Are you menopausal/ premenopausal? Yes<sup>1</sup>    No<sup>1</sup>    If Yes, describe any symptoms you are experiencing: \_\_\_\_\_
- 9) Have you had a hysterectomy? Yes<sup>1</sup>    No<sup>1</sup>
- 10) Have you had an ovariectomy? Yes<sup>1</sup>    No<sup>1</sup>
- 11) Are you on hormone replacement therapy? Yes<sup>1</sup>    No<sup>1</sup>
- 12) What is your libido like? Too high<sup>1</sup>    Too low<sup>1</sup>    No problems<sup>1</sup>
- 13) Do you experience any pain on intercourse? Yes<sup>1</sup>    No<sup>1</sup>
- 14) Do you have any bleeding on intercourse? Yes<sup>1</sup>    No<sup>1</sup>
- 15) Do you experience vaginal dryness? Yes<sup>1</sup>    No<sup>1</sup>
- 16) Do you suffer from yeast infections? Yes<sup>1</sup>    No<sup>1</sup>
- 17) Do you feel sexually satisfied? Yes<sup>1</sup>    No<sup>1</sup>
- 18) How often are you able to achieve orgasm? Always<sup>1</sup>    Often<sup>1</sup>    Sometimes<sup>1</sup>    Rarely<sup>1</sup>    Never<sup>1</sup>
- 19) Does intercourse aggravate or ameliorate your condition? Please explain: \_\_\_\_\_  
\_\_\_\_\_
- 20) Is your sexual orientation an issue for you? Yes<sup>1</sup>    No<sup>1</sup>
- 21) Has masturbation ever been an issue for you? Yes<sup>1</sup>    No<sup>1</sup>
- 22) Are you troubled by vaginal discharges? Yes<sup>1</sup>    No<sup>1</sup>    If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_
- 23) Have you ever had any sexually transmitted diseases? Yes<sup>1</sup>    No<sup>1</sup>    If yes, please list:  
\_\_\_\_\_
- 24) Have you had any problems trying to conceive? Yes<sup>1</sup>    No<sup>1</sup>
- 25) How many times have you been pregnant? \_\_\_\_\_
- 26) Have you had any miscarriages? Yes<sup>1</sup>    No<sup>1</sup>    If yes, how many? \_\_\_\_\_
- 27) Have you had any abortions? Yes<sup>1</sup>    No<sup>1</sup>    If yes, how many? \_\_\_\_\_
- 27) What are the ages of your children? \_\_\_\_\_

Name: \_\_\_\_\_

**Section I: FOR MEN to complete**

- 1) Do you have any prostate problems? Yes  No
- 2) Do you have any difficulty in obtaining or maintaining an erection? Yes  No
- 3) Do you experience premature ejaculation? Yes  No
- 4) Do you feel sexually satisfied? Yes  No
- 5) How often are you able to achieve orgasm? Always  Often  Sometimes  Rarely  Never
- 6) Does intercourse aggravate or ameliorate your condition? Please explain: \_\_\_\_\_  
\_\_\_\_\_
- 7) Is your sexual orientation an issue for you? Yes  No
- 8) Is masturbation an issue for you? Yes  No
- 9) Have you ever had any urethral discharges? Yes  No  If yes, please describe:  
\_\_\_\_\_
- 10) Have you ever had any sexually transmitted diseases? Yes  No  If yes, please list:  
\_\_\_\_\_

**Section J: FOR CHILDREN (Complete only if the patient is a child)**

**a) Mother's pregnancy**

- 1) Did you have any difficulty falling pregnant? Yes  No
- 2) Do you have any other children? Yes  No  If Yes, list ages: \_\_\_\_\_
- 3) Describe any problems you had during pregnancy? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 4) Describe your emotional state during pregnancy, including any stresses that you had?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_

- 5) Check all that apply to describe your labor?    Vaginal delivery<sup>1</sup>    Caesarian section<sup>1</sup>  
Forceps delivery<sup>1</sup>    Used suction<sup>1</sup>    Episiotomy<sup>1</sup>    Epidural<sup>1</sup>    Analgesics<sup>1</sup>    Fetal  
distress<sup>1</sup>    Water birth<sup>1</sup>    Home birth<sup>1</sup>    Had midwife<sup>1</sup>
- 6) Describe any complications during labor? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 8) How long were you in labor for? \_\_\_\_\_
- 9) What did you use for pain relief during labor? \_\_\_\_\_
- 10) Did you breastfeed? Yes<sup>1</sup>    No<sup>1</sup>    If Yes, how long for: \_\_\_\_\_
- 11) Is bedwetting a problem for your child?
- 12) Is masturbating an issue for your child? Yes<sup>1</sup>    No<sup>1</sup>
- 13) What best describes your child's growth and development? Take into account age learning to walk, talk, etc. Failure to thrive<sup>1</sup>    Slow to develop<sup>1</sup>    Average development<sup>1</sup>    Developed fast<sup>1</sup>

**PLEASE SEE NEXT PAGE**

