Health History Form

Personal History:

Name:____ Date ______________________
Address: ____
Phone: __________________________ Email: _______________________________________
Gender: M / F Height __________________ Weight ______________
Occupation: ____
Physician: ________________________________ DOB/Location:_______________________

Condition(s) for which you are seeking homeopathic treatment:

Please state (if known) the health of your mother when she was pregnant with you:

Did your mother suffer from:

_____ anemia _____ toxemia _____ emotional trauma
_____ diabetes _____ vomiting _____ physical trauma
_____ high blood pressure

Please describe any other problems with mother's pregnancy:

Prior to your conception, did your mother use birth control pills, fertility drugs, artificial insemination, etc.?

During pregnancy, did your mother take any medications, use recreational drugs/alcohol, etc.?

Was your birth:

_____ normal _____ breech _____ pre-mature/early
_____ long _____ forceps _____ Cesarean
_____ difficult

Were you breast-fed? ______ For how long? ______

Were you a "good" baby? ______ **Or did you cry a lot**? ______________________

At what ages did you? Start to teeth ______ crawl ______ walk ______ talk ______

Childhood Illnesses:

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

Chicken pox:
German measles:
Measles:
Mumps:
Scarlet fever:
Whooping cough:
Other:

Did you suffer from recurring:

_____ coughs
_____ coughs/chest infections
_____ ear infections
_____ tonsillitis/throat infections
_____ "tummy bugs"

Any other childhood illnesses or emotional upsets (loss/divorce or parent; sexual abuse)?

- **Vaccinations**

If you can, please give ages (or dates) of vaccinations and indicate if there was a bad reaction:

BCG (TB) ______________________
Diphtheria ______________________
DTaP__________________________
Chicken pox ____________________
Cholera ________________________
Gamma globulin _________________
Hepatitis A _____________________
Hepatitis B _____________________
HIB ___________________________
Human Papillomavirus (HPV)
Influenza _______________________
Measles ________________________
Meningococcal___________________
MMR ___________________________
Polio ___________________________
Pneumococcal ___________________
Rotavirus
Rubella ________________________
Shingles________________________
Smallpox _______________________
Tetanus ________________________
Td _____________________________
Typhoid ________________________
Varicella _______________________
Yellow fever ____________________

Any other vaccinations:

- **Hospitalizations :**

Give a brief description of the reasons for any hospitalizations:

Surgeries

Provide brief details of all surgeries to date:

Accidents
Give brief details of any serious falls, burns, broken bones, injuries, etc.:

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

- **Please circle if you have had or have:**

Allergies – Anemia – Cancer – Contagious disease – Diabetes – Hypertension – Cardiac Problems – Epilepsy – Pneumonia – Stroke – Suicidal attempt – Muscular/articular problems – Skin problems – Frequent Urinary Tract infections – Tuberculosis – Obesity – Sexually Transmitted Disease (STDs): syphilis, gonorrhea, chlamydia, HP, genital herpes, HIV hepatitis trichomoniasis

Medications
Please list all medications (including herbal, homeopathic, and vitamin/mineral supplements) that you are currently taking. Also, make a rough list of the doctor-prescibed medications you have taken up to this date.

Indicate below which ailments have affected your relatives. Give ages even if they are/were healthy. Do/Did they have the same ailments as you? Possible ailments: AIDS/HIV, alcoholism, allergies (food, environmental, medications), arthritis/rheumatism, asthma, cancer, diabetes, epilepsy, frequent colds, gonorrhea, gout, hay fever, heart problems (high blood pressure, angina, strokes, etc.), Hepatitis A/B/C, hernia, herpes (oral, genital), hysteria, jaundice, lung disease, mental illness (including suicides), obesity, paralysis, pleurisy, pneumonia, skin problems (eczema, psoriasis), syphilis, thyroid problems, tuberculosis, ulcers, warts (skin, genital), other venereal diseases, and other problems in your family.

	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:			

Other physical/mental/emotional illnesses not listed above OR any information you feel is important for me to know:

Referred by: ____