Date:_____	
Patient #:_____	

HEALTH HISTORY QUESTIONNAIRE FOR CHORONIC CASES

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name:			☐ M ☐ F	**DOB/Age:**	
Marital status:	☐ Single ☐ Married	Phone		E-mail	

PERSONAL HEALTH HISTORY

Head	☐ Vertigo ☐ Heaviness ☐ Dullness ☐ Headache ☐ Feeling Bend around
Eyes	☐ Rings around ☐ Red ☐ Dry ☐ Swelling ☐ Allergies
Nose	☐ Swelling ☐ Dryness ☐ Bleeding
Throat	☐ Tonsils ☐Right ☐Left ☐ Pain ☐ Feeling of lump
Thirst	☐ Increase / Decrease ☐ Cold Hot drinks ☐ Coffee
Taste	☐ Bitter ☐ Sweet ☐ Sour ☐ Tasteless
Tongue	☐ Clear ☐ Red Spots ☐ Broken ☐ Coated
Skin	☐ Warts ☐ Acne (Minor) ☐ Acne (Major) ☐ Rashes/Ulcers ☐ Eczema ☐ Dry ☐ Wet ☐ Color
Hair	☐ Oily ☐ Fall is preeminent
Feet	☐ Hot/Cold ☐ Wet/Dry ☐ Burning ☐ Pain
Joints	☐ Pain ☐ Swelling ☐ Arthritis
Pain	☐ Cutting ☐ Burning ☐ Pricking ☐ Others
Anger level	☐ High ☐ Medium ☐ Low
Fear	☐ Darkness ☐ To be alone ☐ Low
Sleep & Dream	☐ Good ☐ Bad ☐ how many hours..... Any specific dreams
What makes you happy or Unhappy	☐ Happy.....☐ Unhappy
Perspiration	☐ Head ☐Feet ☐ Arm Pits ☐ Any smell
Digestive System	☐ Constipation / Loose motions ☐ Hemorrhoids
Respiratory System	☐ Breathing problems ☐ Asthma ☐ Cough/Dry/Wet ☐ Sleep apnea ☐Snoring
Urinary System	☐ Urine ☐Prostate
Circulatory System	☐ BP High/Low ☐ Heart rate ☐ Anemia
Nervous System	☐ Anxiety ☐Nervousness ☐ Depression ☐ Panic ☐ Fixed ideas ☐ Suicidal thoughts ☐ Appetite
Childhood illness	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio
Impact of Heat & Cold	☐ Minor ☐ Major
Bathing habits	☐ Cold water ☐ Warm/Tepid water
Weather Impact	☐ Summer ☐ Winter ☐ Darkness
Vaccination History:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

List any medical problems that other doctors have diagnosed
1.
2.
3.
4.
5.
6.
List of prescribed drugs and over-the-counter drugs (Including vitamins and inhalers)
1
2
3
4
5
6
Hospitalizations / Surgeries ☐ Yes……..☐No
MEDICAL EXAMINATION
Pulse rate
Blood Pressure
Weight
Height
Eyes ☐ Normal ☐ Dry ☐Any Discharge
Nose ☐ Normal ☐ Dry ☐Any Discharge ☐Snoring
Throat ☐ Normal ☐ Dry ☐Any Discharge ☐Colour
Ear ☐ Normal ☐ Dry ☐Any Discharge
Chest ☐ Normal ☐ Asthma ☐Any Discharge☐Colour

Any Allergies to medications ☐ Yes……..☐No				
Exercise	☐ Sedentary (No exercise)			
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
Food Habits				
	Do you like	☐ Spicy food	☐ Sweet food	☐ Vegetables ☐ Meat
	Salt intake	☐ Hi	☐ Med	☐ Low
	Sugar intake	☐ Hi	☐ Med	☐ Low
	Fat intake	☐ Hi	☐ Med	☐ Low
		☐ Hi	☐ Med	☐ Low
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola
	If yes, # of drinks per day?			
Tobacco	Do you use tobacco?			☐ Yes ☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day ☐ Cigars - #/day
	☐ # of years	☐ Or year quit		

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	

WOMEN ONLY

Pregnancy ☐ Yes ☐No	Any Sexual disorder?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy, are you on family planning pills?		
Age at onset of menstruation:			
Heavy periods, irregularity, spotting, pain, or discharge?		☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____			
Are you pregnant or breastfeeding?		☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?		☐ Yes	☐ No
Any hot flashes or sweating at night?		☐ Yes	☐ No
Any Discharge ☐ Yes…Colour……..Smell…….... ☐ No			
Experienced any recent breast tenderness, lumps, or nipple discharge?		☐ Yes	☐ No

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
Discharge? ☐ Yes…Colour…….. ☐ No ☐ Yes ☐ No		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No
CHILDRENS ONLY		
Growth problem?	☐ Yes	☐ No
Appetite problem?	☐ Yes	☐ No
Learning problem?	☐ Yes	☐ No
Sleep disorders?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No

List of Major and Minor Symptoms			
	Major		**Minor**
1		1	
2		2	
3		3	
4		4	
5		5	
6		6	
7		7	

MODILITIES / EXTREMITIES / AGGRAVATIONS

VISITING NOTES

HOMEOPATHIC CONSENT AND RELEASE FORM

Homeopathy is a system of medicine which offers a holistic and individualized approach to patient health. It utilizes dilute substances derived mainly from plant, animal and mineral sources. The objective of the homeopathic examination is to consider patient entire "picture". It represents patient current state of health (physical, mental and emotional) and enables a Homeopath to select a *homeopathic* medicine that is best suited to you at this time. Nutritional and life style assessment and counseling is often a part of the intake process. When used correctly under the supervision of a qualified practitioner, Homeopathy is considered to be a safe integrative/preventative system of health care. It is not intended to be a substitute for allopathic or traditional medicine. The therapy and information offered should not be construed by you, the client, to be a medical diagnosis of any disease or injury. You should consult with your physician for any serious medical condition.

Please read carefully and sign at the bottom. We are happy to address/answer any questions or concerns.

I acknowledge that I have the option of seeking/continuing conventional medical care from a medical doctor and that homeopathic treatment and conventional medical treatments are different but can complement each other. I confirm that there has been no suggestion made to me that I refrain from seeking or following conventional medical treatment. I recognize that input from my medical doctor is welcome, and the information will be used to augment the homeopathic case-taking process. I am free to withdraw my consent and to discontinue treatment at any time.

While **Syed Ahmed** has had extensive training in the science and art of Homeopathy, I acknowledge that he is not a medical doctor confirm that any prescription medications I am taking under the care of a physician will not be withdrawn without his/her supervision.

I fully understand what has been presented to me with regards to the nature of homeopathic medicines and their safety, and the credentials of my homeopath.

I understand that payment is due at the time services are rendered, unless other arrangements have been made prior to the appointment understand that phone consultations will be billed at the usual Consultancy rate as agreed between patient and Homeopath. I understand that current fees for consultations are as follows, but that there may be changes in the fee structure in the future.

I HAVE READ THE ABOVE AND AGREE TO ALL TERMS:

Patient/Guardian Name:

_____

Signature: _____ Date:

_____