MEDICAL BACKGROUND FORM

Please fill out this form for the person who is being seen by the homeopath. Don't worry if there are some questions to which you don't have answers. Just fill out what you can.

You can type the information into the fields/lines below and email it back to me or you can print it out and fill it out the old-fashioned way.

Name:
D.O.B.:

Name and telephone number of primary care physician:

Mother's name:
Mother's address:
Mother's primary telephone number:
Mother's email address:

Father's name:
Father's address:
Father's primary telephone number:
Father's email address:

Who may we thank for referring you to this office?

What is the main reason you are consulting with a homeopath?

PLEASE STATE (IF KNOWN) THE OVERALL HEALTH OF YOUR MOTHER WHEN SHE WAS PREGNANT WITH YOU:

Did mother experience any emotional trauma, loss or any other major stress during her pregnancy?:
Was your birth induced?:
Did mother use antibiotics during pregnancy or delivery?:
Were you born prematurely?:
Were there any birth complications?:
What was your health like as a newborn?:
Were you breastfed?: If Yes—how long for?:
Did you cry a lot?: If so, why:
Did you spend any time in the NICU or children's hospital?

CHILDHOOD ILLNESSES
Please give 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 any of the following recurring complaints as a child or recently?
Coughs/pneumonia:

Strep?:
Ear infections or ear pain:
Tonsillitis/sore throats:
Asthma:
Any other illnesses:

IMMUNIZATIONS
Please give ages (or dates) of immunizations and indicate if there was a bad reaction:
DtaP/DPT (Diphtheria/Pertussis/Tetanus):
Polio:
MMR (Measles/Mumps/Rubella):
Chicken Pox (Varicella):
HIB:
Hep B:
Pneumonia/PCV (Pneumococcal):
BCG (TB):
Smallpox:
Typhoid:
Yellow Fever:
Cholera:
Gamma globulin:
Influenza:
Pneumonia:
Any other vaccinations for travel or military service:

OPERATIONS
Please list all operations to date:

ACCIDENTS
Please give 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:

MAJOR HEALTH EVENTS
HAVE YOU EXPERIENCED A SIGNIFICANT ILLNESS OR ACCIDENT OR EVENT THAT HAS IMPACTED YOUR HEALTH SINCE IT OCCURRED?:

SENSITIVITY
Are you particularly sensitive to medications or treatments in general or to any in particular?:

Do you have food allergies or environmental sensitivities of any kind, including hay fever? To what?:

Do you believe you might be accurately described as a highly sensitive person in terms of your personality?:

MEDICATIONS AND SUPPLEMENTS HISTORY
Please list all medications and supplements, including herbs, oils, homeopathic and vitamin/mineral supplements that you are currently taking.:

Please list any prescription medications and over the counter medications that you have used in the last **five** years but are not taking now, beginning with the most recent ones. Make note of any that caused any adverse reaction for you. Please be as thorough as possible.:

Please list any prescription medications and over the counter medications that you have used in the last **six** to **ten** years, beginning with the most recent ones. Make note of any that caused any adverse reaction for you. Please be as thorough as possible.**:**

Please list any prescription medications and over the counter medications that you have used **more than ten** years ago, including during childhood, beginning with the most recent ones. Make note of any that caused any adverse reaction for you. Please be as thorough as possible.**:**

FAMILY HISTORY
MOTHER: Date of birth:
Occupation:
Overall health:
Specific problems for mother (in childhood and as an adult):

FATHER: Date of birth:
Occupation:
Overall health:
Specific health problems for father (in childhood and as an adult):

FAMILY HISTORY
Please give as much information as is known regarding the overall health, including major illnesses of close family relatives (including great-grandparents if known). Please mark below if you know, or can find out, if any of the following occurred in your family. Please indicate whether this occurred in:
S=self
M=mother/maternal side
F=father/paternal side
B=brothers or sisters
G=grandparents (please specify maternal or paternal side of family)
C=aunts/uncles/cousins (please specify maternal or paternal side of family)
O=your biological children

ALCOHOLISM:
ARTHRITIS/JOINT PAIN/GOUT:
ASTHMA:
AUTOIMMUNE DISORDER:
CANCER:
DIABETES:
ECZEMA:
EPILEPSY:
HAY FEVER:
HEART PROBLEMS - high blood pressure/angina/strokes/heart disease etc.:
HERNIA/VARICOSE VEINS:
HERPES (oral/genital):
WARTS:
JAUNDICE/HEPATITIS:
VENEREAL DISEASES:
TUBERCULOSIS:
MENTAL CHALLENGES (including OCD, depression, suicides, Alzheimer's):
SKIN PROBLEMS:

Any other important illnesses that run in the family that are not listed above: