MEDICAL HISTORY QUESTIONNAIRE FOR HOMEOPATHY PATIENTS

Judith J. Pruzzo R.Ph., C.C.H.

Please fill in blanks as completely as possible.

Name: ______________________ Age ________ BD: ______________________

Address: ______________________ City: ________ State: ______ Zip Code ______________

If you ever had any of the following, check yes. Note year or age in "When" column

ILLNESSES:	Yes	When?	ILLNESSES:	Yes	When?	MEDICATIONS	Now	When?
A.I.D.S.			Ovarian Cyst			Allergy shots		
Abnormal urinalysis			Parkinson's disease			Anabolic steroids		
Anemia			Persistent hoarseness			Antibiotics		
Appendicitis			Pleurisy			Anti-Candida		
Arthritis			Pneumonia			Anti-coagulants		
Asthma			Poison Ivy			Anti-depressants		
Birth defect (explain)			Prostate infection			Anti-Fungal		
Bladder infections			Psoriasis			Antihistamines		
Blood Disorder			Recurrent chest pain			Anti-malarial		
Bone disease			Recurrent headaches			Anti-thyroid		
Breast tumor or cyst			Rheumatic fever			Anti-tubercular		
Bronchitis			Rheumatism			Aspirin		
Cancer (specify)			Scarlet fever			Birth Control Pill		
Cataracts			Sexual dysfunction			Blood thinner		
Colitis or irritable bowel			Shortness of breath			Chemotherapy		
Convulsions or epilepsy			Sinus headaches			Cortisone		
Diabetes Type I Type II			Sinusitis: acute or chronic			Cough medicine		
Duodenal ulcer			Sore or strep throat			Digitalis		
Ear infections			Stomach ulcer			Diuretic "water pill"		
Eczema			Stroke			Estrogen		
Electro-Magnetic Sensitivity: EMF			Sudden weight gain			Herbal medicines		
Electroshock therapy			Thyroid disorder			Homeopathic meds		
Emphysema/Lung disease			Tonsillitis			Ibuprofen: Advil		
Encephalitis/sleeping sickness			Tuberculosis			Iron supplement		
Endometriosis			Unexplained weight loss			Laxative		
Fainting spells			Venereal Disease:			Narcotic pain relief		
Gall bladder disorder			Chlamydia			Nitroglycerin		
Glaucoma			Genital herpes			Pep pills "uppers"		
Gout			Gonorrhea			Prednisone		
Head or spinal injury			Syphilis			Progesterone		
Heart disease			**Other past or present illness**:		**When?**	Quinine		
Heartburn/acid reflux						Ritalin		
Hemorrhoids						Sleeping pills		
Hepatitis A, B, or C						Sulfa drugs		
High Blood Pressure						Testosterone		
Infection of female organs			**All Rx & OTC Meds/Vit/Min/Herbs**			Thyroid		
Jaundice			**1**			Tranquilizers		
Kidney or bladder disease			**2**			Tylenol: acetaminophen		
Kidney stones			**3**			Vitamins and minerals		
Long confinement from illness			**4**			Wt control "diet pill"		
Malaria			**5**			**Other Past Medications**		
Meningitis			**6**			**1**		
Migraine or severe headache			**7**			**2**		
Mononucleosis			**8**			**3**		
Multiple Chemical Sensitivity: MCI			**9**			**4**		
Multiple sclerosis			**10**			**5**		
Neck or back pain			**11**			**6**		
Nervous breakdown			**12**			**7**		

MEDICAL HISTORY QUESTIONNAIRE FOR HOMEOPATHY PATIENTS

ALLERGIES:		
If check yes, note date/age	Yes	When?
Aspirin		
Asthma Meds		
Codeine		
Darvon		
Demerol		
DPT or MMR vaccine		
Erythromycin		
Food Allergies		
Morphine		
Novocain		
Penicillin		
Sedatives		
Sleeping pills		
Sulfa Drugs		
Tetanus shot		
Tetracycline		
Tree or Grass Allergies		
Xylocaine		

Specify other allergies below:	**When?**

X-RAYS and SCANS	Yes	When?
Back/spine		
Brain scan		
CAT scan		
Chest		
Colon: "Lower G.I."		
Dental X-rays		
Estimate # of Lifetime X-rays:		
Extremities		
Fluoroscopes to fit shoes		
Gall bladder		
Kidney/ureters/bladder		
Liver Scan		
M.R.I.		
Mammogram		
Radiation treatments		
Sonogram		
Stomach: "Upper G.I."		
Thyroid scan		

List other X-rays and date below:

SURGERIES		
If check yes, note date/age	Yes	When?
Adenoids		
Appendectomy		
Breast tumor or cyst		
Ear surgery		
Extremities		
Eye surgery		
Gall bladder		
Heart surgery		
Hemorrhoids		
Hernia: umbilical or inguinal		
Hysterectomy		
Kidney or bladder		
Mastectomy		
Nose surgery		
Ovarian cyst(s)		
Prostate		
Stomach		
Thyroid		
Tonsillectomy		
Varicose veins		
Wisdom teeth extracted:		

List other surgeries below:	**When?**

Injury/Accident/Fracture	Yes	When?
Broken or cracked bone(s):		
Explain:		
Concussion		
Dislocations		
Electrical shock "severe"		
Head injury		
Knocked unconscious		
Laceration "severe cut"		
Sunburn: "severe"		
Explain:		

Current & Past Habits		When?
Alcohol		
Tobacco		
Recreational drugs:		
Cannabis "Pot"		
Cocaine		
Ecstasy		
LSD		
Methamphetamine		
Nutrition: Fair Good		
☐ Healthy Junk food		

VACCINATIONS or DISEASE		
Please check one	**Vacc**	**Disease**
Chicken Pox		
Diphtheria		
Influenza		
Hemophilis influenza B		
Hepatitis: A B		
Measles: 3-day		
Measles: 7-day		
Measles: infantile		
Mumps		
Pertussis:whoop cough		
Pneumonia		
Small Pox		
Typhoid fever		
Typhus fever		
Yellow fever		
Other:		

HAVE YOU EVER HAD ?		
	Yes	When?
Blood test for STD		
Blood transfusion(s)		
EKG:		
Stress Test		

Blood Type: A AB B
O Positive Negative

Present problems or symptoms:
1
2
3
4
5
6
7
8
9
10
11
12

Date symptoms began:

Purpose of visit:

Other pertinent information:

MEDICAL HISTORY QUESTIONNAIRE FOR HOMEOPATHY PATIENTS

Please check any of the following that you currently have, or have had in the past year or two.

Change in the size, shape, color or texture of bowel movements | Hard stool | Constipation | Diarrhea

Urination: Difficult to start | Painful | Frequent: | Daytime | Night | Blood in: | Urine | Stool

Loss of urine: Cough | Sneeze | Laugh | During sleep | If delay going

Joints: Persistent pain | Stiffness | Swelling | Muscle: | Spasms | Cramps | Where?

Lips | Fingers or | Toes turn blue, purple or white from the cold | Night sweats | Hot flashes

Tired, fatigued or weak without apparent reason | Fainting | Faintness | Dizzy | Light-headed

Bruise easily | Discharge from: | Eyes | Ears | Nose | Urethra | Vagina | Rectum

Recurrent nosebleeds | Difficulty swallowing: | Pills | Food | Drink

Enlarged or swollen glands Where?

Short of breath: | Climbing stairs | During sleep | Lying flat

Chronic cough | Cough up blood | Chest pain | Sores or eruption on sexual organs

WOMEN ONLY

Menstrual periods: | Are or | Used to be | Irregular | Regular | Late | Normal | Heavy | Too long

Clots: | Dark | Red | Stop 1-2 days & restart | Brown: | At start | At end

Lasts for: ☐ 2-3 days | 4-6 days | 7-10 days | Spotting: | At ovulation | At start | At end

If painful, describe the type of pain and whether it is in the ovaries, uterus, or abdomen and if it goes to back or legs.

Date of last period: ________ Age periods began: ____ Age periods quit: ______ Date of last Pap smear: ________

Results: | Negative | Positive | Vaginal itching | Vaginal discharge | White | Green | Yellow

Intercourse painful | Vaginal dryness | Use estrogen cream | Need lubricants

Please fill in the number in blanks provided and check those applicable in line below:

Pregnancy: ________ Live birth: ______ Stillbirth: ____ Miscarriage: ___ Abortion: ________ Cesarean : ______

☐ Twins | Triplets | Back labor | Breech birth | Complications from Rh factor

Please give additional information on any difficulties during pregnancy or delivery, as well as menstrual problems or changes that occurred after menopause, childbirth, pregnancy or hormonal medications.

ADDITIONAL INFORMATION FOR CONSULTATION

MEDICAL HISTORY QUESTIONNAIRE FOR HOMEOPATHY PATIENTS

Please check any of the following symptoms or conditions that apply:					
BOWELS and STOOL		**DISCHARGE FROM:**		**COLOR CHANGE WHEN COLD:**	
constipated		ears		hands/fingers	
diarrhea		eyes		feet/toes:	
hard stool		nose		blue	
irritable bowel		rectum		purple	
soft stool		urethra		white	
URINATION		**DISCHARGE TYPE**		**PERSPIRATION:**	
frequent: day		clear		none	
frequent: night		green		scanty	
slow to start		offensive		moderate	
lose urine		thick		heavy	
JOINTS		thin		offensive	
painful		watery		**DIFFICULT BREATHING:**	
stiff		white		climb stairs	
swollen		yellow		sleep apnea	
MUSCLES		**DIFFICULT SWALLOWING:**		**CHRONIC COUGH**	
cramp		dry food		cough up blood	
sore		dry cheese		cough up mucus	
stiff		liquids		must swallow mucus	
tight		pills		sleep with head high	
WOMEN ONLY					
MENSTRUAL PERIODS		**SPOTTING:**		**MENSTRUAL FLOW**	
Now or in the past: irregular		brown		brown	
late		red		heavy	
painful		at start of period		red	
regular		at mid-cycle		very light	
short		at end of period		stop 1 day & resume	
last period began:		**CLOTTING**		**LENGTH OF PERIODS**	
age periods began:		dark red		2-3 days	
age periods quit:		black		4-7 days	
last pap smear:		very large		over 8 days	
FIBROID TUMORS		**MENOPAUSE**		**OVARIES:**	
ovaries		post-menopausal		1 ovary removed	
uterus		peri-menopausal		2 ovaries removed	
PREGNANCY and BIRTH		**LABOR AND DELIVERY**		**CONCEPTION**	
Note number of: abortions		back labor		blocked fallopian tubes	
ectopic		breech		hormone treatment	
live birth		caesarean		in vitro fertilization	
miscarriage		Rh factor		unable to conceive	
pregnancy		triplets		other:	
still birth		twins			
Please relate pertinent information about any of above topics in space provided below.					

HOMEOPATHIC INTERVIEW QUESTIONS

Please put a ☑ or an **X** in the checkbox, if applicable, or a brief answer in blank or on a separate sheet.

Do you finish major things in your life? ☐ High school ☐ College
Desire to have children is or was: ☐ High ☐ Normal ☐ Low ☐ None
Strong or medium desire for: ☐ High ☐ Normal ☐ Low ☐ None
Are you concerned about the opinion of others?
Would you prefer manual labor to mental work?
Do you want affection? Do you return the affection?
Are you fastidious? Careful about order in your house? Always carefully groomed in public?
Is it difficult to rest if there is clutter or dirty dishes in the sink?
Does a crooked picture on the wall; a cabinet or closet door left open bother you?
Are you sensitive to cold air in general?
Do you wear a hat to protect your head or ears from the wind or cold air?
Do you become chilled from a body part being uncovered e.g.: your hand or foot?
Were you fascinated by matches and liked to play with fire as a child?
Do you like to maintain peace and harmony in your emotional environment?
Explain:
Ever witnessed a bad accident, fright, near-accident where you felt bodily injury or death was imminent?
Explain:
Do you have any fears such as: fear of heights, narrow places, water, dark, being alone, animals, bugs,
cockroaches, snakes etc.?
Do you feel unappreciated or lament that you are not appreciated?
Do you have a desire for sausage, ham, bacon or green fruit?
Any worries that your classmates might think you were not good at learning?
Did you ask a lot of questions from the teacher to understand the directions?
Were you considered a tomboy, rather than interested in dolls and housework?
Have you fainted or blacked out? If so, was it from a head injury, from pain, from fear, or other physical
or emotional cause?
Explain:

FAMILY and HEALTH HISTORY

Please put and X in the rows across, if condition has ever applied to blood relative listed in family column (on far left).
If you are adopted, with no knowledge of birth parents check here. ☐

Family Names of close living and deceased relatives	Brother	Sister	Health Status G = Good F = Fair P= Poor	Birth Year	Alcoholic/heavy drinker	Allergies/asthma/sinus	Anemia/hemophilia	Arthritis/rheumatism	Lung/emphysema	Cancer/tumor	Diabetes/glands/thyroid	Stomach/colon	Heart/circulation	Hypertension/stroke	Kidney/bladder	Psychiatric disorder	Migraines	Died from	Age now or when died
Yourself																			
Mother																			
Father																			
Maternal grandmother																			
Maternal grandfather																			
Paternal grandmother																			
Paternal grandfather																			

Check family diseases and list only blood relative affected in space provided, using abbreviations below*

☐ alcoholism	☐ cancer	☐ encephalitis	☐ gonorrhea	☐ malaria
☐ Parkinson's	☐ polio	☐ syphilis	☐ tuberculosis	☐ other:

Abbreviations: P: paternal M: maternal G: grand F: father M: mother A: aunt U: uncle GG:great grand i.e.: PGF: paternal grandfather

PRENATAL and BIRTH HISTORY: Check any that occured when mother was pregnant with you.

☐ alcoholism ☐ hypertension ☐ albumin in urine ☐ kidney infection ☐ German measles ☐ high-risk pregnancy

☐ tobacco use If so, how many packs a day? ___ ☐ chlamydia ☐ gonorrhea ☐ syphilis ☐ Alcohol daily ☐ Meds: ☐ Rx ☐ OTC

☐ crack/cocaine ☐ marijuana ☐ street drugs ☐ uppers ☐ downers ☐ other ☐ antibiotics ☐ aspirin ☐ hormones

☐ cord around neck ☐ eclampsia ☐ toxemia ☐ premature ☐ C-Section ☐ breech ☐ posterior ☐ face-up ☐ forceps ☐ fetal distress

☐ multiple birth # babies ___ ☐ Difficult delivery Birth weight: ___ lbs. ___ oz ☐ Rh problem ☐ blood exchange ☐ resuscitated @ birth

☐ vacuum/suction ☐ other birth difficulties: ___ # Sonograms: ___ ☐ near miscarriage

☐ incubator for: ___ ☐ weeks or ☐ months # children mother delivered before you? ___ # siblings who died at or shortly after birth? ___

If patient is a child or is disabled, who is main caregiver? ___ How many children live with you? ___