Shenandoah Homeopathy

PATIENT HISTORY FORM

PERSONAL INFORMATION

Name *

First Name_____
Last Name_____

Date of Birth *_____

Email Address *_____
Phone *_____

Street Address

Address_____
City_____
State/Province_____
Zip/Postal Code_____
Country_____

Primary reason for this appointment *

(i.e. chief complaint_____

_____

_____

_____

_____

Please list other therapies currently engaged;

_____
_____
_____
_____
_____
_____
_____
_____

INJURIES & DATES;

_____
_____
_____
_____
_____
_____
_____
_____
_____

Birth difficulties/trauma;

_____
_____
_____
_____
_____
_____

Head trauma/concussion;

_____
_____
_____
_____
_____

Dental work;

(tooth extractions, braces, etc.}

Car accidents, falls, sports injuries;

Emotional trauma;

[recent loss of job or loved one]

HOSPITALIZATIONS & SURGERIES;

Procedures & Dates;

MEDICATIONS and supplements;

ALLERGIES & SENSITIVITIES;_____

_____

_____

_____

_____

_____

_____

_____

_____

ILLNESS & TREATMENT HISTORY

Neurological

Please include dates & treatment._____

_____

_____

_____

_____

_____

Ears/hearing;

Please include dates &

treatment_____

_____

_____

_____

_____

_____

_____

Respiratory

(sinus, mouth, throat, lungs) Please include dates &

treatment._____

_____

_____

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_____

_____

_____

_____

_____

_____

Heart, blood pressure

Please include dates &

treatment._____

_____

_____

Digestive

(stomach, liver, intestines, hernia) Please include dates & treatment.

Urinary

(kidney, bladder) Please include dates & treatment.

Musculoskeletal

(muscles, ligaments, bones, spine) Please include dates & treatment.

Skin

(rashes, dryness, lesions, moles) Please include dates & treatment.

REPRODUCTIVE (FEMALE)

Pregnancies_____

_____

_____

_____

_____

_____

Menstrual history

_____

_____

_____

_____

_____

_____

REPRODUCTIVE (MALE)

[Prostate, STDs]_____

PSA

Yes
No

PSA date and results_____

Please circle all that applies to you;

Cancer
HIV/AIDS

Thyroid disease
Diabetes
Mellitus
Eating disorders
Depression
Childhood diseases
Mono
Other

Immunizations

Polio
Pneumonia
Flu
Chickenpox
MMR
HPV
DPT
Tetanus
HEP A
HEP B
Meningitis
Reactions to immunizations

LIFESTYLE

Tobacco

(how much, how often, # years)_____

Alcohol

(how much, how often, # years)

Recreational drugs

(name, how much, how often, # years)

Coffee/tea

(how much, how often, # years)

Hobbies;

Exercise;

Diet

(eating habits, food allergies, cravings,

preferences)

FAMILY MEDICAL HISTORY

Patient's father

(age or age when passed, diseases, conditions, traumas, allergies, significant life events)_____

_____

_____

_____

_____

Patient's mother

(age or age when passed, diseases, conditions, traumas, allergies, significant life events)_____

_____

_____

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_____

_____

_____

Patient's siblings;

(age or age when passed, diseases, conditions, traumas, allergies, significant life events)_____

_____

_____

_____

_____

_____

Patient's children

(age or age when passed, diseases, conditions,

allergies)