MEDICAL HISTORY QUESTIONAIRE

Please complete all pages legibly, and bring, mail, email or fax to

Lucy Vaughters, PA-C, MA-T, CCH—Classical Homeopath

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Name_____Birthdate_____

Address_____city/zip_____

Telephone_____Occupation_____

Work Address, Telephone_____

Marital Status_____Education_____

Email Address_____

FAMILY MEDICAL HISTORY: Please give the following information about your immediate family:

RELATIONSHIP	NAME	AGE IF LIVING	AGE AT DEATH	STATE OF HEALTH OR CAUSE OF DEATH
1. Father				
2. Mother				
3. Brothers				
and				
4. Sisters				
5. Spouse				
6. Children				
7. Grandparents				

Have any blood relatives had any of the following illnesses? If so, indicate relationship (mother, brother, etc.).

ILLNESS	FAMILY MEMBERS	ILLNESS	FAMILY MEMBERS
8. Diabetes/Hypoglycemia		13. Tuberculosis	
9. Cancer		14. Alcoholism	
10. Eczema		15. High Blood Pressure	
11. Epilepsy		16. Heart Disease	
12. Arthritis		17. Allergies, Asthma	

ALLERGIES: List anything that you are allergic to such as certain foods, medications, dust, chemicals or soaps, household items, pollen, bee stings, etc., and indicate how each affects you.

	ALLERGIC TO	EFFECT
1.		
2.		

PAST MEDICAL HISTORY: Please check any of the following illnesses and medical problems you have had, and indicate the year when each started. If you are not certain when the illness started, write down an approximate year.

ILLNESS	YEAR	ILLNESS	YEAR	ILLNESS	YEAR
1. Skin Problems	_____	13. Gallbladder	_____	25. Diverticulosis	_____
2. Eye Problems	_____	14. Hernia	_____	26. Colitis	_____
3. Hearing, Ear Problems	_____	15. Hemorrhoids	_____	27. Gout	_____
4. Bronchitis, or Pneumonia	_____	16. Kidney or Bladder Disease	_____	28. Chicken Pox, Measles	_____
5. Emphysema	_____	17. Prostate Problems	_____	29. Mumps, German Mumps	_____
6. Allergies or Asthma	_____	18. Headaches	_____	30. Arthritis	_____
7. Tuberculosis	_____	19. Seizures	_____	31. Cancer or Tumor	_____
8. Other Lung Problems	_____	20. Head Injury	_____	32. Bleeding Tendency	_____
9. High Blood Pressure	_____	21. Stroke	_____	33. Diabetes	_____
10. Heart Attack	_____	22. High Cholesterol	_____	34. Mononucleosis	_____
11. Venereal Disease	_____	23. Other Heart Conditions	_____	35. Mental or Emotional Difficulty	_____
12. Liver Trouble	_____	24. Stomach/ Duodenal Ulcer	_____	36. Other_____	_____

REVIEW OF SYSTEM: Answer any question as indicated. Place a check mark in front of any general term *ONLY IF YOU HAVE OR HAVE RECENTLY* (6-12 months) *HAD A PROBLEM.*

General health now? Poor_____ Fair_____ Good_____
In your past? Poor_____ Fair_____ Good_____
Weight change? Yes_____ No _____ How much?_____

_____Sleep? hrs./night _____
_____Falling Asleep
_____Early Waking
_____Dreaming
_____Refreshed in A.M.

_____Recurrent Fever
_____Chills
_____Night Sweats
_____Frequent Infections
_____Skin: Rash
_____ Itching
_____ Discoloration
_____ Infections
_____ Slow Healing
_____Joint Pain/Swelling/Stiffness
_____Lumps/Masses
_____Bleeding Disorder
_____Vision
_____Hearing
_____Balance
_____Taste
_____Touch
_____Ringing in Ears
_____Dizziness

_____Sneezing

_____Coughing
_____Breathing
_____Sore Throat
_____Chest Pain
_____Shortness of Breath
_____Faintness
_____Heart Beat
_____Swelling
_____Nausea
_____Gas
_____Heartburn
_____Swallowing
_____Vomiting
_____Constipation
_____Diarrhea
_____Rectal Pain
_____Stomach Pain
_____Blood in Stool

_____Speech
_____Walking
_____Weakness
_____Shaking
_____Mood Changes
_____Personality Changes
_____Headache
_____Thought Process

_____Memory
_____Numbness/Tingling

Men Only
_____Prostate
_____Sexual Difficulties
_____Lumps
_____Pain/Swelling
_____Discharge
_____Urination

Women Only
_____Menstrual Periods
_____Mood Changes
_____Heavy Bleeding
_____Pain
_____Discharge
_____Urination
_____Breast Lumps
_____Breast Pain
_____Breast Discharge
Number of Pregnancies?_____
Children?_____
Type of Birth Control?_____

Do You Smoke?_____
How Much? _____

EXERCISE: Please briefly describe, with an estimate of hrs./week, and any regular exercise.

_____
_____
_____

SPIRITUAL PRACTICE: Describe any regular activity.

_____
_____
_____

MEDICAL HISTORY QUESTIONAIRE **NAME:**_____

PRESENT HEALTH (Please briefly describe all current problems):

Problem/Complaint	**Date of Onset**	**Health Care Provider**

CURRENT MEDICATIONS AND NUTRITIONAL SUPPLEMENTS (with dosages):

_____
_____
_____
_____

PAST HISTORY (hospitalizations, operations, significant injuries):

_____
_____
_____
_____

FOOD DIARY (all food and drink for two recent days):

Day 1:	Breakfast	_____	Liquids	_____
	Lunch	_____		_____
	Dinner	_____		_____
	Snacks	_____		_____
Day 2:	Breakfast	_____	Liquids	_____
	Lunch	_____		_____
	Dinner	_____		_____
	Snacks	_____		_____

Circle the following words which apply to you:

Worthy	Unassertive	Meaningful life	Anxious
Confused	Naïve	Happy childhood	Relaxed
Guilty	Repulsive	Morally good	Nightmares
Misunderstood	Unattractive	Concentrate well	Patient
Unloved	Suicidal ideas	Emphatic	Bored
Sleep well	Unhappy childhood	Confident	Full of regrets
Helpful	Intelligent	Attractive	In conflict

You may use this space to add any additional information that might help your homeopath understand you better.