

# Health Questionnaire



## General Information

Name	Date of Birth
Address	GP Name
Postcode	Surgery
Tel	Mobile
Email	Number of children:
Occupation	<input type="checkbox"/> Married <input type="checkbox"/> Partner <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other

## Presenting Symptoms

Reason for seeking treatment today: \_\_\_\_\_

Please tick the box and/or circle any **persistent** symptoms you have had in the **past few months**. Read through every section and tick "no problems" if none of the symptoms apply to you.

### General

- Unexplained weight loss / gain
- Unexplained fatigue / weakness
- Poor appetite / eating disorders
- Fall asleep during day when sitting
- Fever, chills
- No problems**

### Skin

- New or change in mole
- Itching
- Eruptions / rash
- No problems**

### Allergic/Immune

- Hay fever / allergies
- Frequent infections
- Food sensitivities
- Hives
- No problems**

### Breast

- Breast lump / pain / nipple discharge
- No problems**

### Ears/Nose/Throat

- Nosebleeds, trouble swallowing
- Frequent sore throat, hoarseness
- Hearing loss / ringing in ears / ear pain
- No problems**

### Cardiovascular

- Chest pain / discomfort
- Palpitations (fast or irregular heartbeat)
- No problems**

### Respiratory

- Cough / wheeze
- Loud snoring / altered breathing during sleep
- Short of breath with exertion
- No problems**

### Gastrointestinal

- Heartburn / reflux / indigestion
- Blood or change in bowel movement
- Constipation
- Diarrhoea
- No problems**

### Genitourinary

- Leaking urine
- Blood in urine / pain urinating
- Night time urination or increased frequency
- Discharge: penis or vagina
- Concern with sexual function
- No problems**

### Musculoskeletal

- Neck pain
- Back pain
- Muscle / joint pain
- No problems**

### Endocrine

- Heat or cold sensitivity
- Unstable blood sugar
- Diminished sex drive
- Unwanted hair
- No problems**

### Hematologic/Lymphatic

- Swollen glands
- Easy bruising
- No problems**

### Neurological

- Headache
- Memory loss
- Fainting
- Dizziness
- Numbness / tingling
- Unsteady gait
- Frequent falls
- No problems**

### Eyes

- Change in vision / eye pain / redness
- No problems**

### Psychiatric

- Anxiety / stress / irritability
- Depression
- Hyperactivity
- Sleep problems / insomnia
- Nightmares
- Lack of concentration
- Poor memory
- No problems**

### Women only

- Pre-menstrual symptoms (bloating cramps, irritability)
- Problem with menstrual periods
- Hot flashes / night sweats
- No problems**

## TIME-LINE

Our life story provides useful information which can help direct a homeopath to the most relevant remedy for each individual. On looking at our biographical milestones in chronological order, patterns can emerge and sometimes a realisation that perhaps we have never been quite well since a certain event or experience.

In order to explore this, please complete the form overleaf in brief, making sure to include:

- Major illnesses, including childhood diseases
- Accidents / injuries
- Hospital stays
- Medical treatments / surgical procedures / major dental work, including chemotherapy, radiotherapy and anaesthetics
- Onset of long term prescriptions, including antibiotics, contraceptives, steroids, blood pressure medication, HRT, anti-depressants, sedatives, etc.
- Excessive or prolonged drug use, prescribed or recreational
- Significant shocks, traumas or experiences, including anything which may have had an impact on your mental, emotional or physical well-being
- Problems experienced by your mother during pregnancy, physical or emotional
- Information about your birth, including pain relief and any other interventions

If you are completing the form on behalf of a child, please fill in the details as if from their perspective.

## TIME-LINE



Stage	Year	Age	Event & Comments (if needed)
Pre-birth (Pregnancy)			
Birth			
0-4			
5-10			
11-17			
18-21			
22-30			
30-40			
40-50			
50-60			
>70			



<u>Condition</u>	<u>My Self</u>	<u>Mum</u>	<u>Dad</u>	<u>Siblings</u>	<u>Mum's mum</u>	<u>Mum's Dad</u>	<u>Dad's Mum</u>	<u>Dad's Dad</u>	<u>Other Relatives</u>	<u>Comments</u>
HIV / Aids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney Disease / Failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Miscarriage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Motor Neurone Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Prostate Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chicken Pox / Shingles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sinus Conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sleep Apnoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
STD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Whooping Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

### Childhood Conditions

<u>Disease</u>	<u>Age</u>	<u>Disease</u>	<u>Age</u>
<input type="checkbox"/> Chicken Pox		<input type="checkbox"/> Scarlet Fever	
<input type="checkbox"/> Measles		<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Meningitis		<input type="checkbox"/> Whooping Cough	
<input type="checkbox"/> Mumps		<input type="checkbox"/> Frequent Antibiotics	
<input type="checkbox"/> Rubella		<input type="checkbox"/> Other	

### Infant History

Pregnancy	Normal / Complications		
Delivery	Normal / Forceps / Vacuum / Caes		
Breast Fed	Y / N	Birth Weight	
Crawled	Early /Average / Late		
Walked	Early /Average / Late		
Talked	Early /Average / Late		

### Immunisation History

<u>Vaccine</u>	<u>Age</u>	<u>Vaccine</u>	<u>Age</u>
HBV / Hep B (Hepatitis B)		PCV (Pneumococcal)	
MMR (Measles, Mumps, Rubella)		OPV (Oral Polio Vaccine)	
DTP / DTaP (Diphtheria, Tetanus, Pertussis)		HPV (Cervical Cancer)	
Varicella (Chicken Pox)		Other:	
HbCV / Hib (H. Influenza type b conjugate)			

Please list any adverse reactions:

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