

HEALTH with HOMEOPATHY HEALTH INVENTORY

(This information is confidential and will only be released with your signed consent.)

NAME: _____ Today's Date: _____

ADDRESS: _____ Birth Date: _____

_____ Age: _____ Sex: _____

PHONE: H _____ W _____ C _____

Email address: _____

Legal Status Single Married Divorced Separated Widow/er

Education (yrs completed): Elem ____ HS ____ Coll ____ Voc ____ Prof ____

Occupation: _____ Retired: Yes No Semi

Emergency contact: _____ Phone: _____

If under 18, parents' name and address: _____

Referred by name and address: _____

Family physician name and address: _____

FAMILY HISTORY

Check here if family history is unknown

	Age	If deceased, cause of death
Father		
Mother		
Siblings		

Children	Age	Problems

- | Yes | Blood relative |
|---|----------------|
| <input type="checkbox"/> Alcohol/drug problem | _____ |
| <input type="checkbox"/> Allergy/asthma | _____ |
| <input type="checkbox"/> Anemia | _____ |
| <input type="checkbox"/> Arteriosclerosis | _____ |
| <input type="checkbox"/> Arthritis | _____ |
| <input type="checkbox"/> Bleeding problem | _____ |
| <input type="checkbox"/> Cancer | _____ |
| <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> Epilepsy/seizure | _____ |
| <input type="checkbox"/> Endocrine/hormonal | _____ |

- | Yes | Blood relative |
|---|----------------|
| <input type="checkbox"/> Gastrointestinal | _____ |
| <input type="checkbox"/> Gonorrhea/syphilis | _____ |
| <input type="checkbox"/> Heart disease | _____ |
| <input type="checkbox"/> High blood pressure | _____ |
| <input type="checkbox"/> High cholesterol | _____ |
| <input type="checkbox"/> Kidney/Liver disease | _____ |
| <input type="checkbox"/> Mental illness | _____ |
| <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Suicide | _____ |
| <input type="checkbox"/> Tuberculosis | _____ |

PAST HISTORY OF ILLNESS AND MEDICAL PROBLEMS

Surgery: list all surgery and approximate dates

Other hospitalizations and dates

Broken bones and/or traumatic injuries
(include all car accidents or concussions)

Current health problems
Example: high blood pressure 10 yrs

YES	WHEN	YES	WHEN	YES	WHEN
<input type="checkbox"/> Acne	_____	<input type="checkbox"/> Epilepsy	_____	<input type="checkbox"/> Pelvic infection	_____
<input type="checkbox"/> AIDS	_____	<input type="checkbox"/> Epstein Barr/infectious mono	_____	<input type="checkbox"/> Peptic ulcer	_____
<input type="checkbox"/> Alcohol/drug problem	_____	<input type="checkbox"/> Fibrocystic breasts	_____	<input type="checkbox"/> Periodontal disease	_____
<input type="checkbox"/> Allergies	_____	<input type="checkbox"/> Fibroids	_____	<input type="checkbox"/> Phlebitis	_____
<input type="checkbox"/> Anemia	_____	<input type="checkbox"/> Gallbladder problem	_____	<input type="checkbox"/> Pneumonia	_____
<input type="checkbox"/> Antibiotics more than once a year	_____	<input type="checkbox"/> Glaucoma	_____	<input type="checkbox"/> Premenstrual tension	_____
<input type="checkbox"/> Anorexia	_____	<input type="checkbox"/> Gonorrhoea	_____	<input type="checkbox"/> Prostate problem	_____
<input type="checkbox"/> Anxiety	_____	<input type="checkbox"/> Gout	_____	<input type="checkbox"/> Psychotherapy	_____
<input type="checkbox"/> Arteriosclerosis	_____	<input type="checkbox"/> Hay fever	_____	<input type="checkbox"/> Reactions to vaccinations	_____
<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/> Hearing problem	_____	<input type="checkbox"/> Rheumatic fever	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Heart attack	_____	<input type="checkbox"/> Root canal	_____
<input type="checkbox"/> Back pain/strain	_____	<input type="checkbox"/> Heart failure	_____	<input type="checkbox"/> Scarlet fever	_____
<input type="checkbox"/> Binge eating	_____	<input type="checkbox"/> Heart problem	_____	<input type="checkbox"/> Sexually transmitted disease	_____
<input type="checkbox"/> Bladder infection	_____	<input type="checkbox"/> Hemorrhoids	_____	<input type="checkbox"/> Sinusitis	_____
<input type="checkbox"/> Blood clots	_____	<input type="checkbox"/> Hepatitis	_____	<input type="checkbox"/> Skin problem	_____
<input type="checkbox"/> Breast lump	_____	<input type="checkbox"/> Herpes	_____	<input type="checkbox"/> Sleep disorder	_____
<input type="checkbox"/> Bronchitis	_____	<input type="checkbox"/> Hiatal hernia	_____	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Bulimia (self-induced vomiting)	_____	<input type="checkbox"/> High blood pressure	_____	<input type="checkbox"/> Suicide attempt	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> High chol/tri	_____	<input type="checkbox"/> Syphilis	_____
<input type="checkbox"/> Cataract	_____	<input type="checkbox"/> Hives	_____	<input type="checkbox"/> Taken steroid (cortisone/prednisone)	_____
<input type="checkbox"/> Chemical sensitivity	_____	<input type="checkbox"/> Hypoglycemia	_____	<input type="checkbox"/> Thyroid problem	_____
<input type="checkbox"/> Chicken pox	_____	<input type="checkbox"/> Insomnia	_____	<input type="checkbox"/> Tonsillitis	_____
<input type="checkbox"/> Chronic fatigue	_____	<input type="checkbox"/> Kidney infection	_____	<input type="checkbox"/> Tooth problem	_____
<input type="checkbox"/> Colds, frequent	_____	<input type="checkbox"/> Kidney stones	_____	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Colitis	_____	<input type="checkbox"/> Kidney problem	_____	<input type="checkbox"/> Urine problem	_____
<input type="checkbox"/> Congenital defect	_____	<input type="checkbox"/> Liver disease	_____	<input type="checkbox"/> Vaginitis	_____
<input type="checkbox"/> Counseling	_____	<input type="checkbox"/> Menstrual problem	_____	<input type="checkbox"/> Vision problem	_____
<input type="checkbox"/> Depression	_____	<input type="checkbox"/> Mental illness	_____	<input type="checkbox"/> Warts	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Migraine	_____	<input type="checkbox"/> Other problem	_____
<input type="checkbox"/> Ear infection	_____	<input type="checkbox"/> Nervous condition	_____	<input type="checkbox"/> _____	_____
<input type="checkbox"/> Eczema	_____	<input type="checkbox"/> Neurological problem	_____	<input type="checkbox"/> _____	_____
<input type="checkbox"/> Endometriosis	_____	<input type="checkbox"/> Overweight (>20 lbs)	_____	<input type="checkbox"/> _____	_____
		<input type="checkbox"/> Panic attacks	_____	<input type="checkbox"/> _____	_____

REVIEW OF SYSTEMS

Answer "yes" if you have had these symptoms in the last 6 months

YES

- Chronic fatigue
- Mood swings
- Chronic depression
- Trembling episodes
- Light-headedness
- Food craving
- Frequent infection
- Night sweats
- Swollen glands
- Skin rash
- Chills/fever
- Change in skin/nails
- Change in wart or mole
- Abnormal bleeding/bruising
- Change in hairloss/growth
- Irritability
- Restlessness
- Headaches
- Dizziness
- Balance problem
- Head injury
- Seizure/convulsion
- Poor memory
- Difficulty concentrating
- Fainting
- Weakness
- Numbness/tingling
- Blurred vision
- Double vision
- Loss of any vision
- Halos around lights
- Excessive tearing
- Eye pain
- Dark circles under eyes
- Date last eye exam _____
- Loss of hearing
- Ringing/buzzing in ears
- Sinus trouble
- Nosebleed
- Sore throat
- Hoarseness
- Change in voice
- Dental problem
- Dry mouth
- Excessive salivation
- Bleeding gums
- Mouth breather

YES

- Chronic cough
- Bloody/yellow sputum
- Shortness of breath
 - with exertion
 - at night
- Bronchitis
- Chest pain with breathing
- High blood pressure
- Chest pain or pressure
 - at rest
 - with exertion
 - with stress
 - with eating
 - down left arm, neck or back
 - accompanied by nausea, sweating, or anxiety
- Irregular heartbeat
- Skip beats
- Palpitations
- Fast heart beat
- Heart murmur
- Swelling feet/legs
- Cold hands/feet
- Leg cramps at night
- Joint pain
- Pain or fatigue in legs w exercise
- Burning feet
- Sore legs/feet
- Color change legs/arms
- Difficulty swallowing
- Pain/discomfort with eating
- Bad teeth
- Belching
- Coating on tongue
- Canker sores
- Pain relieved by eating
- Nausea/vomiting
- Trouble with fried foods
- Bloating of abdomen
- Bowel gas
- Diarrhea
- Constipation
- Black stool
- Clay-colored stool
- Mucus in stool
- Hemorrhoids
- Rectal bleeding

YES

- Abdominal pain
- Change in diet
- Pain/burning urination
- Frequent urination
- Urination at night
- Blood in urine
- Foul odor of urine
- Low back pain
- Loss of control of urine

MEN

- Enlarged prostate
- Decreased urine stream
- Unable to interrupt stream
- Dribbling after urination
- Pus or drainage from penis
- Genital swelling or rash
- Problem with sexual function

WOMEN

- Last menstruation period _____
- Age began menstruation _____
- Age at menopause _____
- Number of pregnancies _____
- Number of live births _____
- Number of abortions/
miscarriages _____
- Complication of pregnancy
- Used birth control pills
- Used IUD - type _____
- Usual length of cycle _____
- Usual length of period _____
- Date of last pap smear _____
- Change in cycle
- Spotting between periods
- Discomfort with periods
- Premenstrual tension
- Vaginal discharge
- Painful intercourse
- Itching
- Self breast examination
- Problem with sexual function
- Lump in breast
- Abnormal pap smear
- Infertility

PERSONAL HISTORY

Current medications

List all prescriptions/non-prescriptions and dosage

Vitamin and mineral supplements

Type and dosage

Allergies

I am allergic to the following medications:

Food allergies and method of testing

Lifestyle

List your favorite foods or cravings

I do the following for relaxation/recreation

I am now or have been a smoker Yes No

How many years have you smoked? _____

How much? _____

When did you quit? _____

I estimate my use of

Coffee _____ cups/day Decaf _____ cups/day

I use Beer Wine "hard" liquor

I consider myself a non-drinker social drinker
 heavy drinker alcoholic recovering alcoholic

I use marijuana other drugs _____

I participate in an exercise program Yes No

I exercise on a regular basis Yes No
_____ times _____ week/month

I think this is enough exercise Yes No

I would like to do more exercise Yes No

I find my work satisfactory very satisfying
 too demanding boring

My sex life is satisfactory Yes No

I sleep well Yes No

I worry about money job family life
 relationships other _____

I currently see a psychotherapist or
other mental health professional Yes No

I have had a therapeutic massage Yes No

I currently see a chiropractor, osteopath, or
other physical therapy person Yes No

I have been arrested Yes No

I have been in the military service Yes No

I have been a victim of abuse physical sexual
 emotional

My spiritual life is satisfactory Yes No

I am currently involved in a regular
spiritual program Yes No

My last physical exam was _____