



sam adkins  
homeopathy

## adult health history

### PATIENT DETAILS

Name: \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_

Email \_\_\_\_\_

Phones: \_\_\_\_\_ H \_\_\_\_\_ W \_\_\_\_\_ M \_\_\_\_\_

Occupation: \_\_\_\_\_ Marital status \_\_\_\_\_ No of children \_\_\_\_\_

#### GP

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

### MAIN HEALTH ISSUE

What problem would you like treated (please describe)

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List your current symptoms and any factors which make them better/worse (activity/rest/foods/temperature/weather etc)

Symptom \_\_\_\_\_ Modifying factor \_\_\_\_\_

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When did this start? (Include here any events that preceded it such as change of job, moving house, after an illness.)

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Please list all conventional and complementary medical treatments you have tried so far for this issue. Please rate them on a scale of 1 (low efficacy)-5 (highly efficacy)

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### Additional health Issues

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List any medications/supplements/herbs are you currently taking?

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### PATIENT GENERAL HEALTH INFORMATION

Do you have? Please rate all of the following on a 1-5 scale (1 is low severity and 5 is high severity)

Allergies/sensitivities to Drugs (eg penicillin)

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Foods

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Environmental( eg pollens or dust)

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#### DIGESTIVE SYMPTOMS

Pain

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Bloating

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Indigestion

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Diarrhoea

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Constipation

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Wind

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#### FOODS

What foods do you crave?

When?

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What foods do you severely dislike?

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#### SLEEP PROBLEMS

Difficulty getting to sleep

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Waking during sleep

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How do you feel on waking?

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#### SYMPTOMS IN OTHER AREAS? (PLEASE CIRCLE ANYTHING CURRENT)

Head / Eyes / ears / nose / teeth / chest / urinary tract / menstrual / reproductive / skin / skeletal

Do you have currently or in the past (please circle)

Eczema / asthma / hayfever

#### BODY TEMPERATURE

Do you .....prefer to be (please circle)

Cool / Cold / Warm / Hot

What is your favourite weather and why?

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Do You Perspire?

Where?

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ENERGY LEVELS ON SCALE OF 1-10 (WITH 1 BEING LOW AND 10 BEING VERY HIGH) 1 2 3 4 5 6 7 8 9 10

#### MORE ABOUT YOU

Fears or phobias

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Smoking (how many per day?)

Alcohol (units per week)

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Recreational drugs (which/when)

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### YOUR MEDICAL HISTORY

**Birth/Infant:**

**Your mother's health during pregnancy?**

**Did you experience any birth trauma?**

**Breastfed? Yes/no**

**How long**

### CHILDHOOD:

**Did you have childhood vaccinations reactions?**

**Recurring infections? Yes/no**

**Where?**

**Approx number of courses of antibiotics taken in total?**

### PLEASE GIVE DETAILS OF ANY ADDITIONAL HEALTH ISSUES YOU HAVE HAD (INCLUDING OPERATIONS, VIRUSES, INJURIES)

0-5

5-10

10-15

15-20

20-30

30-40

40-50

50-60

60+

### FAMILY MEDICAL HISTORY

Please list known diseases of family members (skin problems, heart disease, high blood pressure, cancer, diabetes, mental illness, other)

**Mother**

**Father**

**Close Family**

### DESIRED OUTCOME FOR YOUR TREATMENT?

### ANYTHING ELSE YOU WANT ME TO KNOW?