MEDICAL HISTORY FOR HOMOEOPATHIC TREATMENT

Directions for a written submission

INTRODUCTION

1. For finding a correct homoeopathic remedy lot of information with regard to the
   (i) Complaints
      (a) Main as well as
      (b) Subsidiary and
   (ii) The person of the patient is required.

2. Incomplete information will make correct choice difficult. You are therefore requested to supply all information without keeping back anything as irrelevant or of little importance. The information you supply in the Note forms the basis of further enquiry designed to assist you in the further delineation of the problem. Full co-operation therefore is requested. All information supplied is, of course, strictly confidential.

3. We are sure you be fully co-operating with us in rendering you the best possible service.

PRELIMINARY INFORMATION

Please supply the following information as standard routine:

Name in full :

Address :

Date of Birth :

Sex:

Status (Single / Married / Widow-ed since / Divorce since):

Religion /Community/Sect :

Vegetarian / Non-vegetarian / Eggs :

Addictions, Tobacco, chewing/smoking :

Tea, Coffee, Beer, Whisky and liquors (please state the quantity consumed daily):

Educational career and qualifications :

Occupation, current and previous with a full description of responsibilities and job satisfaction, address and tel. no. Description of the current family set-up:

Full description pertaining to all the members their ages, location, work they are doing and your relationship with responsibilities for them. Include in your list those who have Died stating the age of death, the year and cause of the same. Your daily routine from getting up in the morning to retiring at night. Include in this your dietary schedule furnishing full details in respect of the quantities consumed.

Financial responsibilities and strains (present as well as past). Difficulties experienced, Place of work / Family set-up Social, give a full account.

CHIEF COMPLAINT

Describe what bothers you most. Each trouble should be detailed as under :

1. Full description of the trouble right from the time of onset. Its subsequent development and spread and response to treatments taken. This should give full idea of:

(i) Area affected : location, extension, direction of spread the march of events.

(ii) Sensation experienced in the area of trouble.

(iii) Conditions that have brought on the trouble; examine the circumstance that obtained just before or at the time of onset, paying attention to physical as well as emotional factors.

(iv) Conditions that increase the trouble or those that afford relief.

(v) Other troubles experienced at the same time along with the main trouble for example perspiration/nausea/vomiting/gas/with pains.

OTHER COMPLAINTS

Describe here all other troubles you might be having or have in the past experienced. Each should be described fully as suggested above for the 'CHIEF COMPLAINT'.

PERSONAL DATA

Give a full account of the following:

(1) Physical description of self

(2) Emotional nature and intellectual attainments and aspirations. Indicate to what extent you have been responsibilities in life and what you feel about them.

(3) Reactions to surroundings.

(a) Food desires and aversions, foods that do not suit etc.

(b) General environment: weather, temperature, bath, recreations, addictions etc.

(c) Sleep and dreams

(d) Sex (inclusive of menstrual and obstetric history).

PREVIOUS ILLNESS

Give a resume of the various illnesses you had and to what extent these have any bearing on present troubles.

FAMILY HISTORY

Data concerning the parents, brothers and sisters. State details concerning the health of wife and children.

GENERAL COMMENTS

Include here any items which have not been included above.

ENCLOSURES

1. Medical Report and opinion on your state of health from physician.
2. Copies of Reports of investigations done.
3. X-ray plates, Electrocardiograms, etc.