Homoeopathic History Proforma

Please rest assured all the details you provide will remain completely confidential.

DATE:

NAME:

AGE & SEX:

ADDRESS:

TEL.NO.:

Email ID:

OCCUPATION:

DIAGNOSIS:

CHIEF COMPLAINT:

(how it started, why do you think it started, how it progressed, what makes it worse, better, etc.) (If you can think of a reason for the complaint, that’s very important. Mention any possible emotional or physical factors that may have played a contributory role in developing the problem)

ASSOCIATED COMPLAINTS: (any other health problems that you suffer from…in as much detail as possible as regards origin, duration, progress..)

MEDICATIONS THAT YOU ARE ON OR HAVE BEEN ON IN THE PAST (long-term):

PAST HISTORY:

(Vaccination / animal bites / other illness-surgery that you may have had in the past / any known allergies)

Is there some ailment that you have a tendency for, that makes you sick repeatedly?

Have there been any sort of reactions to any of the vaccinations received?

*IMPORTANT:* When was the last time you developed a high fever? [Of over 39 deg C (102 deg F)]

Are there any birthmarks or moles on your body?

FAMILY HISTORY: (any illness that you know your relatives to be suffering from)

Father:

Mother:

Your position amidst siblings:

No. of brothers:

 Ailments, if any:

No. of sisters:

 Ailments, if any:

Is there a history of cancer or TB in the ancestral line?

|  |  |  |
| --- | --- | --- |
|  | Paternal | Maternal |
| General disease tendencies |  |  |
| Grandfather |  |  |
| Grandmother |  |  |

HABITS:

(smoking, drinking, etc.)

GENERALS

Appetite

Speed of eating

How does hunger affect you

When do you feel hungry, when not

Thirst (how many glasses per day, whether you prefer cold water or not)

Food (likes, dislikes, foods which don’t suit you, grade them intensity wise, with 1 being low grade and 3 being high grade intensity of like/dislike…for e.g., if you like milk a lot, write L3 next to milk, if you dislike spicy food averagely, write D2 next to spicy)

Are you - Vegetarian / Non-vegetarian / Vegan?

Sweet

Sour

Spicy

Salt

Salty food/savoury

Bitter

Milk, plain, without sugar

Milk, sugared

Milk, flavoured

Ice

Coffee

Tea

Aerated drinks

Cold

Warm

Fruit juice

Sugar

Eggs

Meat

Chicken

Fish

Ham/bacon

Vegetables

Leafy greens

Fruits

Nuts

Rice

Bread

Chapati

Cakes

Pastries

Ice cream

Chocolates

Fats

Butter

Cheese

Cream

Paneer

Ghee

Fried food

Soup

Salad

Onions, (raw)

Ginger

Garlic

Tobacco

Alcohol

Others which may not be in the list

Any food allergies

STOOLS

When are you constipated?

When do you suffer from diarrhoea?

Flatulence/gas?

URINE

PERSPIRATION

Scanty/average/excessive?

When?

On what parts?

Odour / Staining

Heat / burning of palms – soles

SLEEP

Position

How soon after going to bed

How many hours required

Deep / Light

Disturbed by noise/light/anything else

Afternoon sleep

Short nap

Problems before/during/after

Covering the body, if required, what parts

 Do any parts need to be kept uncovered

Snoring / grinding teeth / eyes or mouth open / talking / walking / weeping / restless / salivation

DREAMS (any recurring themes, etc.)

MENSTRUAL HISTORY

FMP

LMP (date of last period)

Cycle

Type of flow

Flows most when

Before / during / after

Staining / odour / clots

Leucorrhoea/white discharge

OBSTETRIC HISTORY

 Contraceptive use

SEXUAL LIFE

HOW DO THEY AFFECT YOU –

Hot weather / cold weather / wet weather / clouds / sun

Change of weather

Thunderstorm

Wind

Drafts of air

Warmth of room

Change of temperature / weather

Fan and AC

Covering

Bath

Standing long

Strong odours/perfumes

Riding in cars / boat / plane

Seaside

Mountains

Tight clothing

Crowded places / lifts / heights

Examinations

Moon phases

Any side preponderance of ailments?

What time of day/night do you feel your best or worst?

Any problems with --

Nails

Hair

Skin

Teeth

Taste

Wound healing

FOR CHILDREN

Birth history

Vaccinations

Milestones

Habits like thumb sucking, nail biting, eating indigestible things like chalk, wall plaster, mud, etc., bed wetting, etc.

Behavioural problems

FOR CHILDREN'S CASES, PLEASE GIVE HISTORY (EMOTIONAL, MENTAL AND PHYSICAL) OF MOTHER DURING PREGNANCY:

MENTAL SYMPTOMS

Greatest grief

Greatest joy

How do you stand worries?

When do you weep?

How does consolation affect you?

In what circumstances have you felt jealous?

How do you react?

When do you feel frightened or anxious?

How do you deal with emotional hurts?

What about revenge?

When do you get nervous?

What makes you angry?

How do you react?

Can you stand waiting?

How patient/impatient are you with others?

How rapidly do you walk, talk, eat, work?

In times of depression, how do you look at death?

How orderly, particular, duty-conscious are you?

How is your memory?

What sort of people do you dislike?

What sort of people do you like?

How much do you like company / socializing?

Are you extroverted / introverted?

How easily do you spend money / do you gamble?

How easily do you trust others?

How is your self-confidence and decision taking ability?

What are your priorities in life?

What is the most important thing for you in life?

What are your ambitions or goals?

What are your hobbies?

What according to you are your own negative points?

Is there anything you have any insecurities about?

What are the things that bother you?

What changes do you want to bring into your life?

What 'issues' are you struggling with generally in life or currently?

What are your regrets or frustrations in life?

Tell me about your life or what has happened to you in your life:

LIFE : Please describe:

Parents:

Other influences:

Childhood years:

School and college years:

Marriage:

Professional Life:

Other aspects of your personal life:

Describe your nature as per your view: