***Teresa Mhic Dhonncha, I.S.Hom, Lic GCH***

*Registered Homeopath & Asyra Practitioner*

**

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**PATIENT MEDICAL HISTORY FORM**

DATE \_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_

NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TELEPHONE Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How many years in job?\_\_\_\_\_

Job satisfaction out of 10? \_\_\_\_ Job stress levels out of 10?\_\_\_\_

Name and number of GP May I contact him/her ? yes/no

Have you seen a Nutritionist/Naturopath before? Yes/No

**Please list your Primary Health Concerns:**

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medication- including supplements:**

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**Family Health:**

Father – \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Siblings - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Diseases and Treatments:**

This is a partial list of some common illnesses or conditions. Circle any you have suffered, and give details below of treatment of these as well as any others not on this list.

Abscess Acne Alcoholism Allergy Anemia Angina Anxiety Arthritis Asthma Back pain Bleeding Bronchitis Chronic Fatigue Conjunctivitis Constipation Cramps Cystitis Depression Diabetes Diarrhoea Dysmenorrhea Eczema Fevers Fibroids Fissures Glandular fever Gout Headache Haemorrhoids Hepatitis Hernia Herpes Hyperactivity Hypertension IBS Influenza Insomnia Infertility Jaundice Liver disease Malaria Malignancy ME Meningitis Menstrual disorders Menopausal flushes Migraine Miscarriage Neuralgia Night Sweats Otitis media Paralysis Phobias Pneumonia Polyps Prostatitis Psoriasis Rheumatism Shingles Sinusitis Tinnitus Tonsilitis Ulcers Urticaria Vertigo Verrucas Warts **Infectious**: Chicken pox Cholera German measles Measles Mumps STD Typhoid Whooping cough

Illness History Age Duration Medicines taken

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Have you had any major accidents or injuries? If yes, give details:

Please list any known allergies, including food/drug/animals/environmental:

Do you use any of the following, and if so, is this sometimes or frequently?

Alcohol / Coffee / Recreational drugs /Sleeping Pills / Tea / Tobacco

List Food Desires & Aversions

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Signature

*Thank you for your co-operation!*