

HEALTH HISTORY FORM



**H.D Mona Lisa Ashkar *BSc, H.D,
D.H.M.H.S***

305 Milner Ave. Suite 209

(Markham Rd. & 401)

Scarborough, ON

M1B 3V4

Tel: (416) 817-9245

Email: info@h3naturalmedicine.com

Member of O.H.A

Dear Patient

To select the best possible remedy for you, I need your co-operation. Homeopathic remedies are mainly selected on the symptoms which you provide to me. Therefore, I need your full support in providing me with the most accurate information. I need to get to know "YOU" as the unique individual, which you are. The following questions are just the beginning of the journey to know "you" completely. Please take your time while filling out the form.

All information is kept **STRICTLY CONFIDENTIAL** and will not be released without your written consent.

Thank you.

HEALTH HISTORY FORM

Date: _____

Personal Information

Name: _____

Age: _____ Date of Birth (M/D/Y) _____ Sex: _____

Address _____

City: _____ Postal Code: _____

Home Phone: _____

Fax: _____

Work Phone: _____

E mail: _____

Marital Status: S M D W Sep

Number of Children: _____

Number of Pregnancy's: _____

Occupation: _____

Emergency Contact Information

Name: _____

Phone: _____

This person's relation to you: _____

HEALTH HISTORY FORM

MAJOR COMPLAINTS IN ORDER OF IMPORTANCE:

COMPLAINT	SINCE	CAUSE

HEALTH HISTORY FORM

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

MEDICATION	SINCE	ADVERSE EFFECT

Have you had homeopathic treatment before? **YES** **NO**

If YES;

What remedies have you been taken? _____

When was your last remedy dose? _____

Which remedy? _____

Are you on any other treatments? **YES** **NO**

If YES;

What kind of treatment? _____

Are you taking any Vitamins/Supplements? **YES** **NO**

If YES; List them and how often you take them:

1. _____

2. _____

3. _____

HEALTH HISTORY FORM

If you currently have **(Check with X)**. If had in the past **(Check with P)**.

ABSCESSES	EAR INFECTION	HIGH BLOOD PRESSURE	PELVIC INFLAMMATORY DISEASE	STREP THROAT
AIDS/HIV+	EMPHYSEMA	HYPOGLYCEMIA	PLEURISY	SUNSTROKE
ALCOHOLISM	EPILEPSY	INFLUENZA	PNEUMONIA	STROKE
ALLERGIES	GALL STONE	KIDNEY DISEASE	POLIO	SYPHILIS
AMNESIA	GOITRE	KIDNEY STONE	PROSTITIS	THYROID PROBLEMS
ARTHRERITIS	GONORRHOEA	LEUKEMIA	RHEUMATIC FEVER	TONSILITIS
ASTHMA	GOUT	MALARIA	RHEUMATISM	TUBERCULOSIS
BRONCHITIS	HAY FEVER	MEASLES	RUBELLA	TYPHOID FEVER
CANCER	HIATIAL	MENINGITIS	SCARLET FEVER	VENEREAL
	HERNIA			WARTS
CHICKEN POX	HEART ATTACK	MISCARRIGE	SCIATICA	WARTS
COLD SORES	HEART DISEASE	MONONUCLEOSIS	SEXUAL ABUSE	WHOOPIG COUGH
COLITIS	HEMORRHOIDS	PANCREATITIS	STD	YELLOW FEVER
DEPRESSION	HEPATITIS	PARASITES	SKIN DISEASE	
DIABETES	HERPIES GENITALIA	PERITONITIS	SINUSITIS	

Other conditions _____

Are there any of the preceding conditions after which you have never been totally well again? _____

HEALTH HISTORY FORM

WHAT OPERATIONS HAVE YOU HAD?

OPERATION	WHEN	COMPLICATION

WHAT MAJOR INJURIES HAVE YOU HAD?

INJURY	WHEN	LONG TERM EFFECT

HOW MUCH OF THE FOLLOWING SUBSTANCES ARE YOU USING?

Coffee:	Recreational drugs:
Tea:	Cigarette/cigar:
Alcohol:	Chewing tobacco:

Which vaccinations have you had? _____

Any adverse effects from them? _____

Have you lost weight recently? **YES NO** How many Kg/Pounds? _____

Have you gained weight recently? **YES NO** How many Kg/Pounds? _____

Female: Age of first menses: _____

HEALTH HISTORY FORM

FAMILY HISTORY

RELATIVE	AGE IF ALIVE	AGE AT DEATH	AILMENTS
MOTHER			
FATHER			
BROTHERS			
SISTERS			
CHILDREN			
MATERNAL GRANDMOTHER			
MATERNAL GRANDFATHER			
PATERNAL GRANDMOTHER			
PATERNAL GRANDFATHER			

SELECT THE FOLLOWING AILMENTS IN YOUR FAMILY HISTORY

AIDS/HIV+	ARTHRITIS	DEPRESSION	GONORRHOEA	INSANITY	THYROID PROBLEMS
ALCOHOLISM	ASTHMA	DIABETES	GOUT	SKIN DISEASE	TUBERCULOSIS
ALZHEIMER'S	CANCER	EPILEPSY	HEART DISEASE	SYPHILIS	THYPHOID FEVER

Signature: _____

Thank you for taking the time to fill this form. The information you have provided in this form and during the case is very valuable in assessing your health and choosing the proper remedy for you.