PATIENT DETAILS

Name ……………………………………………………….……………………………
Date of Birth ………………………………………………………………………
Address ………………………………………….……………………………
……………………………………………………….…………………………..
……………………………………………………….…………………………..
Telephone …......………………………………………………………………..
Mobile ……………………………………………….……………………………..
Email address………………………………………………………………………

Name of GP ………………………………….…………………………………….
Address of GP …………………………………………………………………..
………………………………………………………..……………………………..
Name of Specialist Practitioner ……………………………………………………
Address ……………………………………….……………………………………
……………………………………………………………………………………

Consent: I hereby confirm that I have requested Homeopathic treatment from Alison Endenburg.

Signed ………………………………
Dated ……………………………….

MEDICATION AND TREATMENT TO DATE

Please list all current medication, vitamins and supplements you are taking…………
…………………………………………………………………………………...
……………………………………………………………………………………
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Please list any long-term prescriptions you have taken, and when you were on them e.g. the pill, HRT, blood pressure tablets etc ………………………………………….
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Please mention any other therapies you have used, and the ailments they were used for
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Holistic
Health

Please list vaccinations and any reactions to them …………………………………….
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Do you have any allergies or intolerances ?……………………………………….
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Please state any recreational drugs you have used or use…………………………..
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MEDICAL HISTORY

Please list all illnesses, diseases, accidents, operations, hospitalisations and medical tests you have had, and if possible the year or your age when you had them. …….…
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Please list the childhood illnesses you had and if possible, the year or your age at the time
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Have you experienced any life traumas e.g. bereavement, divorce etc? When? ………
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FAMILY MEDICAL HISTORY

Please provide information regarding your blood relatives, both living and dead.
In each case please state which relative and their approximate age when they had the following:

Alcoholism………………………………………………………………………...
Drug use/abuse…………………………………………………………………….
………………………………………………………………………………………….
Please state which drug/s ………………………………………………………….
………………………………………………………………………………………….
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Down's Syndrome………………………………………………………………….
Epilepsy …………………………………………………………………………...
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Behavioural problems …………………………………………………………….
………………………………………………………………………………………….
Diabetes ……………………………………………………………………………
Cancer …………………………………………………………………………….
Depression ………………………………………………………………………….
Stroke ……………………………………………………………………………..
Suicide / attempted suicide ……………………………………………………….
Heart attack ………………………………………………………………………….
Asthma ………………………………………………………………………………
Glandular Fever……………………………………………………………………
Tuberculosis ………………………………………………………………………..

Please state any current illnesses of your relatives suffer from.
e.g. high blood pressure, rheumatoid arthritis, recurrent chest infections, hay-fever, eczema, anxiety, sexually-transmitted diseases, etc

Paternal Grandmother ………………………………………………………………..
Paternal Grandfather ………………………………………………………………
Maternal Grandmother ……………………………………………………………
Maternal Grandfather ……………………………………………………………..

Mother ……………………………………………………………………………….
Father ………………………………………………………………………………..

Aunts ..……………………………………………………………………………….
Uncles ………………………………………………………………………………...

Siblings ……………………………………………………………………………….

Thank you for taking the time to fill in this questionnaire.