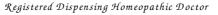
HEALTH QUESTIONNAIRE FOR HOMEOPATHIC TREATMENT (FEMALE)



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First Name:	Gender:	FEMALE
Middle Name(s):	Age:	
Surname:	Date of Birth:	
Occupation:	Weight:	
	Height:	

PLEASE READ THROUGH ENTIRE QUESTIONAIRE BEFORE ANSWERING!

When answering, please note that it is in your best interests to give as much detail as possible, the more accurate and complete the information given the better I am able to help you.

Please describe pains as fully as possible, using words such as:

sharp, dull, jerking, boring, tearing, burning, bursting, pulsating, constricting, cramping, numb, numb yet with pain, cold, etc...

If pain moves from one part to another - name the parts/describe. Give the sensations in your own language no matter how simple, or even ludicrous. State what makes the pain better or worse - such as:

pressure, movement, rest, seated, standing, walking, heat, cold, food, sea-air, coition, time of day, time of year, bathing, taking a very hot shower, etc...

AS FAR AS POSSIBLE, PLEASE GIVE YOUR OWN UNIQUE DESCRIPTION IN YOUR REPLY, THE IMPORTANCE OF THE INFORMATION YOU GIVE IS IN THE INDIVIDUALITY OF YOURSELF AND NOT JUST A YES OR NO ANSWER.

	ANSWER
1 Colour of Eyes?	
Hair:	
Complexion:	
Relationship status:	Single / partner / married / widowed / divorced

Describe your **MAIN COMPLAINT(S)**:

When did it begin? What makes it better or worse? When is it better or worse? What do you think caused it? What other symptoms may accompany this main complaint?

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Is there pain/itch, skin raw, inflamed?

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13 URINE: If painful, burning, frequent,	
involuntary/difficult. If there is pressure,	
sediment, odour, retention - give colour.	
Do you go at night? What time/s?	
14 FEMALE GENITALIA:	
Describe any pain, itch, discharge,	
swelling, skin eruptions etc.	
How would you describe your sex drive?	
History of illness in this area:	
MENSTRUATION: Contraceptive use?	
State number of days between period.	
How many days duration?	
Is the discharge - scanty, profuse,	
flooding, bright red, dark, black,	
clotted, membranous?	
Is there pain, tension, headache, breast	
changes or trouble, backache before/ during/after a period? DESCRIBE	
Is there any discharge between periods? If so, describe colour/odour/amount, etc.	
Does it burn the skin?	
Is there downward pressure?	
State if there has been sterility,	
miscarriage, pregnancy or operation.	
Have you gone through menopause?	
If so, are you adjusted to the 'Change'?	
How long has any condition existed	
and what treatments have you had?	
15 BACK: Position of pain in shoulder, ba	ack,
waist, seat or spine, better or worse for?	
16 LIMBS: If pain, is it in: muscle, nerve,	
joint or skin & exact location – better/worse	
for movement/rubbing/weather changes etc	D.
17 SKIN: If rough, itching, burning, dry or	
moist. Describe any strange sensations,	
eruption, rashes, inflammation, odour or	
peeling. State parts affected.	
18 PERSPIRATION: Do you - at all?	
If so, where do you start perspiring from?	
And when exactly? Does it smell? A lot?	
Does it discolour clothing? What colour?	
19 GENERAL: Do you feel better:	
Indoors or outdoors?	
In cool air or a warm room?	
When resting or moving about?	PTO

<u>HEAL</u> 7	<u> TH QUESTIONNAIRE FOR HOMEOPATHIC TREATMENT (FEMALE)</u>
19 At night or during the day? What	
In Summer/Autumn/Winter/Spring?	
When hot/cold? Wet/dry weather?	
At the seaside or inland/mountains?	
Describe your weekly physical exercis	e.
20 SLEEP: If restless, disturbed.	
When you waken - what time/s?	
What wakens you? Is it pain, worry,	
emotion, excitement, dreams?	
Are your troubles better or worse	
at night?	
What position do you sleep in?	
What do you dream about?	
	ntoms of the Mind and Disposition ARE MOST IMPORTANT and should be
carefully considered and reported. Give	this section your particular thought.
How would you describe yourself?	
Describe your hopes, dreams, desires	
and <i>fears</i> :	
What do you spend most of your time	
thinking about / to what do your	
thoughts tend to gravitate around?	
What is your favourite activity?	
What is the most important aspect of	
your life and why?	
Describe 5 positive characteristics	
AND 5 negative characteristics about	
yourself:	
If you could change one thing about	
yourself what would that be and why?	
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What traits do you like the least in	
others?	
Are there any observations that others	
close to you have commented on about you?	
How would you describe your	
emotional state?	
What is your religious belief?	
What role does this play in your life?	

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23 Have you suffered from any of the following?
Rheumatic fevers Scarlet fevers Glandular fever
Typhoid Cholera Bilharzias
Malaria OR prophylaxis Mumps Tumours / Cancer
Diabetes Measles Whooping Cough
Bronchitis Pneumonia Heart Disease
Sinusitis Hepatitis Yellow Jaundice
X-ray, MRI, CT or Radium/Cobalt Treatments?
When last were you immunized?
List all immunization received?
Do you smoke? For how long and how many?
Do you drink Alcohol? How much and for how long?
Describe any operations &/or accidents.
Is your food cooked in aluminium pots?
List & date all destinations travelled to
recently & in the past: (Outside the Western Cape)
24 ALL CURRENT MEDICATION & SUPPLEMENTS: Please list full name and dosage:
25 Family Medical & Social History: (Please also include any major family problems/issues)
Mother:
Mother's Mother:
Mother's Father:
Father:
Father's Mother:
Father's Father:
26 ANY COMMENTS YOU MAY WISH TO ADD: