

HEALTH HISTORY QUESTIONNAIRE FOR HOLISTIC AND HOMEOPATHIC TREATMENT / DR. CHERNIN

NAME OF PATIENT / CLIENT _____ DATE _____

Note: This assessment form may take more than one sitting to complete. Give yourself enough time to write your answers. Completing this form is mutually beneficial. It will help Dr. Chernin and will contribute to your own self-knowledge.

A. DIET

Record all food and fluid taken for four days before your appointment.
List all supplements and dosages you are taking.

Example:

Monday, October 2, 2003

Breakfast-7:30 a.m. Fruit bowl with apple, banana, grape, raisins,
a half a cup of milk & honey.
1 slice of whole wheat toast/butter

Snack-10:00 a.m. 1 cup of tea with honey (chamomile).

Lunch-1:00 p.m. Tossed green salad with tomato, mushrooms, carrots, green peppers, & yogurt
dressing.

Mixed bean salad (kidney, garbanzo, navy)

Rice & broccoli casserole

1 cup herb tea, Vitamin C-100 mg.

Dinner-6:00 p.m. Steamed zucchini, tomatoes, & carrots, brown rice, cheese.

1 8-oz glass 2% milk. Vitamin E-400 units.

Your Diet

Day 1

Day 2

Day 3

Day 4

B. FAMILY MEDICAL HISTORY: List parents, grandparents, children, and spouse's ages, medical conditions, cause of death.

Note: history of alcoholism, mental illness, tuberculosis, diabetes, cancer, nerve disease, venereal disease, kidney disease, miscarriage, inherited diseases, or colon diseases—ulcerative colitis, polyps, villous adenoma.

Also, note significant illness outside immediate family members—cousins, aunts, and uncles

Your Family History

C. CASE HISTORY: List in order of their importance, your present problems or illness.

In homeopathy, the sum total of your symptoms is the basis for your treatment.

Describe:

1. When and how the trouble began, as well as any changes that may have taken place since.
2. What treatments have been used?
3. What things—positions, foods, drinks, temperature, weather, time of day, thoughts, or emotions— make it better and which make it worse? — Most valuable are unusual or apparently contradictory symptoms, such as: lack of thirst during a fever.
4. What precedes, accompanies, or follows the problem — e.g. nausea with headache, exhaustion after diarrhea?

Your Case History

D. PAST HISTORY: List all the previous illnesses in the order that they occurred.

Give a complete history of your health problems arranged in the order they occurred.

Describe such things as skin diseases, fever, sores, ulcer, children's diseases & immunization reactions.

Also, list injuries, their location & what treatment was used.

List hospitalizations in order of their occurrence.

E. GENERAL SYMPTOM REVIEW:

IMPORTANT: Whenever describing pain, include its location, its quality: cutting, aching, tearing, drawing, pulsating, etc.

Whether it moves through the body, the time of day it appears. Does pain occur with nausea?

What makes it better or worse: lying down, sitting, movement, sun, smoke, etc.?

Whenever describing discharges from any part of the body—nose, vagina, eyes, lungs, wounds, etc.,

Include:

Whether it is scanty or copious, its color, and odor.

Whether it is thick, thin, gluey, sticky, causes redness or burning, rawness, and the color of its stain.

What makes the discharge better or worse and what time of day does it appear?

Do the various discharges from your body have any characteristics in common: color, tendency to irritate skin, thickness.

1. **MENTAL:** These statements look like a lot; however all this is most important, so we can evaluate *your* specific condition as fully as possible. Circle the most relevant answers and write added information if you desire.

What situations cause _____? Give examples.

anxiety—at night, being alone, in a crowd, your future, your health, before menses, anticipating events, etc.

confusion—after eating, before menses, after a nap, etc.

fear—hearing bad news, that others would see you afraid, of: darkness, falling, heart disease, heights, going crazy, robbers, death, ...

irritability—after sex, after eating, before menses, during perspiration, etc.

depression—for no reason, after eating, before or during menses, after physical exertion, on walking...

anger—How do you handle this? If someone hurts your feelings?

frustration—How do you handle this?

you to be startled—waking up, going to sleep, noise, being touched, etc.?

you to make mistakes—call things by wrong name, speaking, telling time, omitting letters, using wrong words...

you to be over-sensitive to _____ (what things)?

you to be critical to others, or self?

your mind to feel dull?

discouragement?

crying?

Suspicious of others?

Do you ever feel _____? When and why?

greedy

indecisive

overly concerned about little things

cowardly

rude

overly egotistical

deceitful

sulking

overly fastidious

averse to being touched

homesick

disagreeable

very obstinate

averse to business or work

self-pity

anxiety

overly shy

averse to men or women

quarrelsome

despair

easily hurt

everything seems unreal

selfish

restless

easily offended

fear from religious thoughts

self-confident

in a hurry

that you talk too much

Do you ever _____? When and why?

dwell on past disagreeable events?

like company or prefer to be alone?

have hallucinations or overly active imagination—about what?

have unusual impulses—such as to run a car off the road, jump off of buildings or bridges, etc.?

have strong mood changes?

have kleptomania?

laugh inappropriately?

have a desire for being powerful?

sigh a lot?

not like people speaking to you?

have persistent thoughts—about what things?

throw things?

like being consoled when you feel sad or anxious?

feel overly affected by sad stories or movies?

have problems with criticism?

feel sad about, or disappointed in, love?

have thoughts of suicide or self-harm?

how do you think about it, what are your plans?

2. **HEAD:** Describe headaches, hair problems such as dandruff, bald spots, early grayness. Describe eruptions and discharges from the scalp.

3. **EYES:** Describe your eyesight. Any pain, discharges, spots, flickers, itching, infections, sties?

4. **EARS:** Describe your ears and hearing. Any pain, discharges, noises (such as ringing, chirping, roaring, etc.), bleeding, infections, eruptions in ear or on ear lobes?

5. **NOSE:** Describe your sense of smell—particular odors in your nose, pain, discharges, bleeding, polyps. Is your nose stuffy in the morning, at night or outdoors? Do you have allergies? If so, what?

6. **MOUTH AND THROAT:** Describe unusual taste or odor in the mouth: in the morning or after eating.
Describe pain in: teeth, tongue, or throat.
What is the condition of your teeth? Do your gums bleed?
Is there a coating on the tongue?
Do you have difficult swallowing, or thyroid problems?
Do you have sore throats frequently and if so, on which side of the throat?

7. **CHEST:** Describe any chest pain, expectoration; shortness of breath, cough, asthma, bronchitis.
When do the symptoms occur and what makes them better or worse?

8. **GASTROINTESTINAL:** How is your appetite? Do you prefer hot or cold drinks?
Are you frequently constipated? What is the stool color & odor?
Are the stools hard, large, dry, pasty, bloody, watery, flat, frothy, slimy?
Circle foods you really like a lot – **Put a line through** foods you dislike a lot
Put an X through foods that cause gas, heartburn, nausea, diarrhea.
Salty sweets sugar sour meat milk onions fruit unripened fruit meat
smoked meat fish grains oysters chocolate coffee beer wine

9. **URINARY:** Is there pain before, during, or after urination?
What is the color, odor, and quantity of urine?
Is urination frequent or urgent?
Is there a history of urinary infection?

10. **REPRODUCTIVE:** Women: Age of first menstruation. How far apart are your periods?
Is there pain before, during, or after your periods?
Does the pain extend to your back, side, groin, thighs?
Describe the pain: how often does it appear, what relieves or aggravates it?
Has the quality of your periods changed over the years?
Note any history of: vaginitis, venereal disease, pregnancy, miscarriage.
Is intercourse normal, unsatisfactory, or painful?
How does your period affect your moods? Breasts swell before period?

Men: Give particulars as to disorders of sex organs, present practices and adjustment, if anything is unusual or causes difficulty.
What is the effect of intercourse? Are there night emissions?
Note any history of: venereal disease, urethritis, or prostatitis?

11. **SKIN:** In skin, scalp or nail troubles: tell the exact location, color, whether dry or moist, thick or thin, scaly, pimples—with or without matter. Note appearance of surrounding skin.
Is there a history of warts or moles?
Is there itching or burning? Is this relieved by scratching?
What makes the symptoms better or worse—heat, cold, wool, water?
Are there any enlarged veins? Where?

12. **BONES, JOINTS, BACK:** Describe pains, stiffness, swelling, heat, inflammation, nodules.

13. GENERALITIES: Are you a chilly or warm-blooded person?

Write the time of day, night, month, or season that you are, in general, better or worse—
before or after: eating, sleeping, moving, resting
when occupied
when thinking of your trouble, etc.

Write exactly what conditions characteristically make you worse and which usually relieve pain or sickness. *This is very important.*

Are you affected by: different kinds of weather, cold, dampness, heat, dryness, approaching storms, thunderstorms, frost, cloudiness, seashore, low or high altitudes, etc.

Are you affected by: bathing, lying down, perspiring, tight clothing, loose clothing, laundry work, the beginning of motion, riding in cars: do you get nauseated? The wind?

How are you affected by physical activity? Are you weak, weary, or lazy

Sensations are important. State what kind of sensations you feel, where, at what time they appear, what make them better or worse.

Tell about all sensations, however slight or peculiar, for example: "as if...
something alive were moving in my stomach,"
a tight band were around my head,"
a nail were being driven into the side of my head"

Any unusual or recurrent dreams? What are they?

F. LIFESTYLE AND HABITS

1. LIVING SITUATION: Alone, group, couple-married status, children, dependants. Who does the food preparation, selection?
How much time do you (and can you) have alone? What are your previous living situations? Any pets?

2. EDUCATIONAL BACKGROUND: Formal and informal. What are your hobbies and other areas of interest?

3. WORK HISTORY: What is your work experience?

4. DRUG USE: (What is not mentioned before) Please include: all over-the-counter preparations, prescription medications, "recreational drugs", alcohol, caffeine, and tobacco.
What is the frequency of use?

5. **EXERCISE HABITS:** Please include an exercise record and specify time spent on each. Include: jogging, calisthenics, hatha yoga, walking, stretching, other sports.
6. **RELAXATION:** Do you have a regular relaxation program? How do you relax?
7. **TRAVEL:** Home, as well as abroad. What foreign countries have you visited, lived in: how long, any problems incurred?
8. **PREVENTION:** Do you and your family use seat belts? Are you using smoke detectors in your home? Do you or your children wear bicycle helmets? How many hours of TV do you watch weekly?
9. **MEDICAL TESTS:** List date and result of last test:

<u>TEST</u>	<u>YEAR</u>	<u>RESULT</u>
Cholesterol	_____	_____
Blood sugar	_____	_____
rine test	_____	_____
Mammogram	_____	_____
Breast exam	_____	_____
PSA	_____	_____
EG	_____	_____
Chest -ray	_____	_____
Stress EG	_____	_____
pper GI	_____	_____
Colonoscopy	_____	_____
Stool test for blood	_____	_____
Sigmoidoscopy	_____	_____
Skin check for moles	_____	_____
MRI	_____	_____
CT scan	_____	_____
ltrasound	_____	_____
Dental exam	_____	_____

10. **IMMUNIZATION HISTORY:**
- | <u>TYPE</u> | <u>YEAR</u> | <u>TYPE</u> | <u>YEAR</u> |
|-------------|-------------|-------------|-------------|
| DTP | | Hepatitis B | |
| Polio | | Flu | |
| MMR | | Chicken pox | |
| HIB | | Other | |