Health Inventory Form

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How did you hear about us? (ex. Advertisement, media, referral, internet, etc.)

This information is confidential and will only be released with your signed consent!

Today's Date: ______________________________

Personal Information

Name:	
Address:	
Email:	
Cell Phone:	
Home Phone:	
Work Phone:	
Birthdate:	
Age:	
Sex:	
Height:	
Weight	
Occupation	

In Case of Emergency

Contact Name	
Relationship	
Phone Number(s)	
Family Physician	
Physician Phone	
Physician Address	

Concerns (rank by priority) *Example: headache*	**Onset** *Oct '03*	**Frequency** *3 times/day*	**Severity** *Mild/Moderate/Severe*

Family History

	Age	If deceased, cause of death
Father		
Mother		
Sibling		
Sibling		
Sibling		

Your own children

First Name	Age	Problems/conditions

Check any items that apply to blood relatives (children, siblings, parents, grandparents, aunts, uncles) and state the relationship
Ex. Type 1 Diabetes-father

✓	Condition	Relationship
	Alcohol/drug problem	
	Allergy/asthma	
	Anemia	
	Arteriosclerosis	
	Arthritis	
	Binge eating/bulimia	
	Cancer	
	Epilepsy/seizure	

	Heart disease	
	Skin disease	
	Endocrine/hormonal imbalance	
	High blood pressure	
	High cholesterol/fat	
	Kidney disease	
	Obesity	
	Stroke	
	Suicide	
	Thyroid disease	
	Tuberculosis	
	Gastro Intestinal disease	
	Syphilis	
	Gonorrhea	

Review of Systems

No	Yes	System	Problem
		Cardiovascular (chest pain ,HBP, fainting)	
		Respiratory (shortness of breath, wheezing)	
		Metabolic (thyroid disorder, abnormal blood sugars)	
		Neurological (headaches, numbness, dizziness)	
		Gastrointestinal (Irregular bowel habits, cramping)	
		Skin (rashes, acne, dryness)	
		Musculoskeletal (joint pain, muscle pain, spasms)	
		Ear, Nose, Throat (hearing, sinus congestion, allergies)	
		Vision (blurred, seeing spots)	
		Difficulty sleeping, Fever, Wt loss/gain	
		Sexual function (poor desire, trouble having orgasm)	
		Urinary (Kidney stones, frequent urination)	
		Mental/Emotional (depression, panic attacks)	

Health Inventory Form

Women: Please Answer

Questions:	**Answers:**
Last menstruation period	
Age began menstruation	
Usual length of cycle	
Usual length of period	
Age at menopause	
Numbers of pregnancies	
Number of live births	
Number of abortions/miscarriages	
Date of last period	

Men: Please check any that apply

✓	**Condition:**
	Enlarged prostate
	Decreased urine stream
	Dribbling after urination pus/drainage from penis
	Genital swelling/rash
	Problems w/sexual function
	Unable to interrupt stream

Women: Please check any that apply

✓	**Condition:**
	Complication with pregnancy
	Use birth control
	Change in cycle
	Use IUD (please list what type: ____)
	Spotting between periods
	PMS
	Vaginal discharge
	Infertility
	abnormal paps
	Lumps in breasts
	Itching
	Problems w/sexual function
	Painful intercourse

Health Inventory Form

Have you had any surgical procedures or traumatic injuries? (List all surgery and approximate dates — also include all car accidents and concussions)

Procedure	Date

Any other Hospitalizations? (Please include dates)

Reason for hospitalization	Date

What are your goals for this visit?

Please list any prescription medications you are currently taking

Medication *Ex. Lipitor*	Reason *High Cholesterol*	Year Started *2002*	Dosage *10mg/once a day*

Please list any supplements, herbs or homeopathics you are currently taking

Brand or name *Ex. Siberian ginseng*	Reason *energy*	Year Started *2004*	Dosage *250 mg/twice a day*

Please list any food or drug allergies you have and the reaction you experience (if a food allergy, explain the method for testing the allergies)

Allergen	Reaction

LIFESTYLE

What interests/hobbies do you have?

List your favorite foods and cravings

What physical activities to you participate in?

What complementary/alternative therapies have you tried or are currently using?

What are the stressors in your life?

What do you do to relax?

Please answer any questions that apply:

Tobacco? ___No/Never ___ Yes ___Formerly *(From age ____ to ____ ; _____ packs per day)*

Health Inventory Form

Alcohol? ___No/Never ___ Yes *If yes:*
Estimated drinks per day: ______
Started drinking at age: ______
I drink: _____ *beer* _____*wine* _____*"hard" alcohol*

Other Drugs? ___No/Never ___ Yes *If yes, type and frequency:* ______________________________

Exercise regularly? ___No/Never ___ Yes *If yes:* ___ *times per week;* ____ *times per month*

Is your sex life satisfactory? ___No ___ Yes

Have you ever been arrested? ___No ___ Yes

Have you ever been in the military? ___No ___ Yes *Are you currently in the service?* ______

Is spiritual life satisfactory? ___No ___ Yes *Are you currently in the spiritual practice?* ______

Have you been a victim of abuse? ___No ___ Yes *If yes:*
____ *Physical*
____ *Sexual*
____ *Emotional*

Do you worry a lot? ___No ___ Yes *If yes, what do you worry about:*
____ *Money*
____ *Job*
____ *Family life*
____ *Relationships*
____ *Other:* ____

I find my work: ____ Too demanding ____ Boring ____ Satisfactory ____ Very satisfying

When was your last physical exam? Date: ______________________

Tell me one thing about yourself that you are proud of: