Homoeopathic case taking format - Record-keeping

Dr Mahwish Nosheen

It is important that you must read this before giving record:
I try my level best to cure you with proper care. As it is just to inform you that in Homoeopathy it is necessary to select a best remedy for you, I need your full co-operation and support. As in Homoeopathy remedy selection depends upon the "Totality of Symptoms" so I will ask many questions to you during this time period and you have to answer me for best prescription. Because Homoeopathic system of medication depends upon "Individualization" so I will consider even a very minute and even common symptom, might be I will help me out to select the best one. And all this include your "Reactions to environment, Family history, personal history, past history" and relevant to above mentioned data etc. so it is important that you should understand each thing that belongs to you as an individual.

So, this information and your co-operation will enable me to select your best possible single remedy.

Regarding this one thing is most important that you should frank with me, and freely answer my questions, and don't think that this is useless question or this is not relevant to you, because might be this one minute thing leads towards best prescription. And read everything in this Performa and try your level best to answer of every question or even you can consult this with your any closed one to complete this.

At the most important thing that keep it in you mind that whatever you are telling me or writing in this Performa will be remain confidential.

Parts of questionnaire:
This questionnaire consists following parts:
1. History regarding your chief complaints.
2. History regarding your present illness
3. History and questions regarding you past history and family history.
4. Environmental factors relevant to your illness, so please think about each question carefully and then answer.
5. Mental illness, this is very important portion regarding your history, so think carefully and answer because sometimes in homoeopathy remedy selection depends upon "Psychology"
6. Dreams
7. Sleep
8. Especially for children or you are as a child
9. This portion is very important because in this portion you are given the instructions on how to report each of your complaint, so 1st only read the given instructions and then make a list of your complaints and then describe the each complaint according to the instructions.

CONFIDENTIAL

Name:
Age:
Sex:
Address:

Telephone: **Work Place Contact#:**

Religion:
Occupation (Type of work):
Education:
Vegetarian/ Non-vegetarian/Egg. Vegetarian single:

Divorced/Widow:

LMD:
EDD:

Date:

CHIEF COMPLAINTS:

PAST/PREVIOUS HISTORY:
In this history it is important to note that have you any disease in your past. Because, sometimes current problem relates with previous one. No doubt it is a fact that any disease, Poisoning, Drug, or any accident leaves it mark and remains in your system as a weak point, and that can be mush more than our imaginations. In homoeopathic treatment it is necessary to know about all the previous ailments to give strength your body. So, it is important that you tell us about your previous ailments that you have suffered from in the past and the other treatments that you have taken.

Below a list is given just encircle that one disease/illness so far suffered and then move on next page to give its relevant details

D.N	D.N	D.N	D.N
Typhoid Cholera Food Poisoning Worms Diarrhoea Dysentery	Measles German measles Chicken-pox Small-pox Mumps Whooping cough	Malaria Jaundice Any Liver Spleen or Gall Bladder Disease	Miscarriage Abortion Currettings Sickness during Pregnancy etc. Prolapse of uterus
Malnutrition Rickets Rheumatism Backache	Any venereal Disease like Syphilis Gonorrhoea etc.	Any heart trouble , Blood pressure , Giddiness	Nephritis (Kidney or urine trouble) Diabetes etc. Prostate trouble
Any operation such as Tonsils , Abdomen , Appendix , Hernia , Piles, Uterus , Renal Stone , Gall Stones, Phimosis , Hydrocele , Cataract etc. Mode of anaesthesia : general –local	Diphtheria, Septic Tonsils , Adenoids Recurrent infections – Sinusitis Bronchitis – Eosinophilia Cold 0-Fever-Chill . Pneumonia Asthma –Pleurisy—T.B.		Any serious shock , grief , disappointments, fright , mental upset , depression or nervous break down
Chronic Headaches, Numbness , Cramps, Fits , Convulsions Polio, Paralysis etc. Meningitis –Any Lumbar puncture done.	Any major accident or injury to body or head. Any occasion of unconsciousness Any major bleeding from any part of the body.		Skin diseases like Pimples , Boils, Carbuncles, Ringworms, Fungus, Scabies , Eczema. Ulcers on any part of the body.

Regarding your past:

Cause of Disease/Disease Suffered From	Duration	Approximate age	Any other medication and treatment you are taking/ have taken	Whether you completely recovered?	Any other particulars

Any other information you want to share regarding this:

Write the name of any Narcotic, Drug, Medicine etc. that ever you used in your life time:

FAMILY HISTORY:
Encircle the Disease you have from your any relation/Family member, also encircle that relation:

S.N	**List of Major Diseases**		**Family Relationships**	**Age**	**Alive/Dead**	**Cause of death**	**Disease Relation**
1.	Anaemia		Paternal Grand Father/Mother/Maternal Grand Father/Mother/Uncle/Aunt/cousin Brother/Cousin Sister/Cousin's Brother or Sister from Mother's side/ Cousin's Brother or Sister from Father's side				
2.	Cancer		Paternal Grand Father/Mother/Maternal Grand Father/Mother Uncle/Aunt/cousin Brother/Cousin Sister/Cousin's Brother or Sister from Mother's side/ Cousin's Brother or Sister from Father's side				
3.	Diabetes		Paternal Grand				

			Father/Mother/Maternal Grand Father/Mother Uncle/Aunt/cousin Brother/Cousin Sister/Cousin's Brother or Sister from Mother's side/ Cousin's Brother or Sister from Father's side				
4.	Insanity		Paternal Grand Father/Mother/Maternal Grand Father/Mother Uncle/Aunt/cousin Brother/Cousin Sister/Cousin's Brother or Sister from Mother's side/ Cousin's Brother or Sister from Father's side				
5.	Rheumatism		Paternal Grand Father/Mother/Maternal Grand Father/Mother Uncle/Aunt/cousin Brother/Cousin Sister/Cousin's Brother or Sister from Mother's side/ Cousin's Brother or Sister from Father's side				
6.	T .B. /Pleurisy		Father / Mother				
7.	Leprosy		Paternal Grand Father/Mother/Maternal Grand Father/Mother Uncle/Aunt/cousin Brother/Cousin Sister/Cousin's Brother or Sister from Mother's side/ Cousin's Brother or Sister from Father's side				
8.	Epilepsy/Fits		Father / Mother				
			Diseases From				
1.	Bleeding Tendency		Uncle/Aunt/cousin Brother/Cousin Sister/Cousin's Brother or Sister from Mother's side/ Cousin's Brother or Sister from Father's side				
2.	Urticaria		Uncle/Aunt/cousin Brother/Cousin Sister/Cousin's Brother or Sister from Mother's side/ Cousin's Brother or Sister from Father's side				
3.	Eczema		Uncle/Aunt/cousin Brother/Cousin Sister/Cousin's Brother or Sister from Mother's side/ Cousin's Brother or Sister from Father's side				
4.	Asthma		Uncle/Aunt/cousin Brother/Cousin Sister/Cousin's Brother or Sister from Mother's side/ Cousin's Brother or Sister from Father's side				
5.	Paralysis		Uncle/Aunt/cousin Brother/Cousin Sister/Cousin's Brother or Sister from Mother's side/ Cousin's Brother or Sister from Father's side				
6.	Hypertension		Uncle/Aunt/cousin Brother/Cousin Sister/Cousin's Brother or Sister from Mother's				

			side/ Cousin's Brother or Sister from Father's side				
7.	Heart Troubles		Uncle/Aunt/cousin Brother/Cousin Sister/Cousin's Brother or Sister from Mother's side/ Cousin's Brother or Sister from Father's side				
8.	Kidney Diseases		Uncle/Aunt/cousin Brother/Cousin Sister/Cousin's Brother or Sister from Mother's side/ Cousin's Brother or Sister from Father's side				
9.	Liver Diseases etc.		Uncle/Aunt/cousin Brother/Cousin Sister/Cousin's Brother or Sister from Mother's side/ Cousin's Brother or Sister from Father's side				
10.							
11.							
12.							

If have any confusion regarding above details can ask and if you wants to add more can write below:

How many siblings you have (Brothers & Sisters, including those who died, if any)?
Provide the information regarding above mentioned Question in the table below:

S.N	Name of Brother/Sister	Age	Alive/Dead	Disease if have any
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

If you want to add more information regarding this you can write below:

PERSONAL HISTORY:

This history includes you personal from your childhood to till, or if child then take the history from close relation like Mother/Father:

1. About you birth
2. Did your Mother take any drug during pregnancy?
3. Did your Mother have any disease/problem during Pregnancy?
4. Was there any problem during your birth give details if have?
5. At what age you start followings:

S.N	Stage	Age	Yes	No
1.	Sitting			
2.	Teething			
3.	Standing			
4.	Walking			
5.	speaking			
6.	Habit of eating Indigestibles like Lime, Chalk, Soil, Slate, Pen etc			
7.	Urine Control/Bed Wetting			
8.	Any other problem regarding your Growth & Development			

Encircle "Y" if there is any animal bite and if no then Encircle "N" :

S.N	**Name**	**Y**	**N**
1.	Dog	Y	N
2.	Cat	Y	N
3.	Snake	Y	N
4.	Scorpion	Y	N
5.	Rate	Y	N

If any other then mention below:

Did you ever take any anti-rabies or anti-venom or any other treatment like this:

History of Vaccination or any Inoculation if you have taken:

Indicate the number of times was Vaccinated for the followings:

S.N	Name of Disease	Number of times you vaccinated
1.	Cholera	
2.	Small Pox	
3.	Polio	
4.	Measles	

5.	B.C.G	
6.	Typhoid	
7.	Tetnus	
8.	B.C.G + Typhoid + Tetnus Triple	

Mention if you have any trouble or reaction from above mentioned Vaccinations/Inoculations:

If you are "MARRIED" then give details about the health of your Husband/Wife:

Information about your children how many you have? Number of dead children if any, with proper causes, inform about following details:

S.N	Child's Name	Male/Female	Age	Alive / Dead	Disease if any
1.					
2.					
3.					
4.					
5.					
6.					

Any other condition like:
Abortion
Miscarriages
Still birth

Data of Personal habits:

S.N	Personal Habits	How much
1.	Smoking	
2.	Snuffing	
3.	Alcohol	
4.	Chewing Tobacco	
5.	Sleeping Pills	
6.	Alcohol	
7.	Tea	
8.	Laxatives/Purgatives	
9.	Any Other	

If you have any other information regarding above mentioned table write below:

MAIN COMPLAINTS WITH THEIR DETAIL HISTORY AND ASSOCIATION WITH THE RECENT TROUBLES ALONG WITH OTHERS LIKE:
Onset
Course with detail

ORIGIN AND CAUSE:
Try to trace out your actual cause and origin of your Illness like:
Any mental disturbance like Shock, Worry, Depression etc:
Errors in Diet and Regimen:
Over exertion:
Exposure to Cold/Heat

THIRST AND APPITITE:
Give your answer correctly:

1. How is your appetite?
2. When are you hungry?
3. What happens if you have to remain hungry for long?
4. How fast do you eat?
5. How much thirst do you have?
6. Any particular times are you especially thirsty?
7. Do you feel any change in your taste and feeling in your mouth?

LIKES AND DISLIKES:
It is very much important that you must fill up the table given below carefully as most of the times remedy selection depends upon your likings and disliking.

Please write "Y" if you like/Dislike something and write 2 times "YY" if you strongly like or dislike something in the table is given below:

S.N		Like	Dislike	Disagrees	S.N		Like	Dislike	Disagrees
1.	Bitter				11.	Eggs			
2.	Salt extra				12.	Spicy food			
3.	Sweet				13.	Meat			
4.	Sour				14.	Fish			
5.	Bread				15.	Cabbages			
6.	Butter				16.	Onions			
7.	Fats				17.	Warm food/drink			

8.	Milk				18.	Cold food/drink			
9.	Coffee				19.	Fruits			
10.	Mud/chalk				20.	Anything else			

If you want to put any other information regarding above mentioned table please write below:

STOOL:

1. Do you have any problem regarding your stool?
2. When and how many times a day you pass stool?
3. When you feel urgency?
4. Do you have any problem about bowel movements?
5. Do you have to strain for stool? Even if soft?
6. Do you have belching or passing gas? Describe its character along with Aggravations and Ameliorations
7. How do you feel after passing gas up or down?
8. Do you feel better/be upset before/during/after passing stool?

If you have any other information regarding your stool complaints then you can write below with detail:

URINE:

1. Any problem about the urine?
2. Any strong smell/odor? Like what?
3. Do you have any trouble before, during and after passing urine?
4. Any difficulty about the flow? Slow to start, interrupted, feeble dribbling etc.?
5. Any involuntary urination? When?
6. What is the colour of Urine write it correctly?
7. Do you feel Burning before/during/after urination?
8. Do you feel that you want to pass urine but unable to urinate?
9. Do you feel any sedimentation in urine after passing?

If you have any other information/complaint regarding urination you can write below with proper detail:

Patient's signature:

Submission Date:

Follow up Date:

Prescription:
R_x: