

INFORMATION FOR YOUR PHYSICIAN DATE:

| | |
|-------------------------------|---------------------|
| NAME: | DATE OF BIRTH: |
| ADDRESS: | HOME PHONE: |
| CITY, STATE, ZIP: | CELL PHONE: |
| SEX: M F MARITAL STATUS: | NUMBER OF CHILDREN: |
| EMERGENCY CONTACT: | PHONE NUMBER: |
| REFERRED BY: | |
| EMAIL: | |

LIST MEDICATIONS YOU ARE CURRENTLY TAKING

| MEDICATION | SINCE | EFFECTS |
|------------|-------|---------|
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LIST ANY ALLERGIES

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MAJOR COMPLAINTS

| COMPLAINT | SINCE | CAUSE |
|-----------|-------|-------|
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LIST ANY TREATMENT/REGIMES YOU ARE FOLLOWING

| TREATMENT | SINCE | RESULTS |
|-----------|-------|---------|
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LIST ANY OPERATIONS YOU HAVE HAD

| OPERATION | WHEN | COMPLAINTS |
|-----------|------|------------|
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LIST ANY MAJOR INJURIES

| INJURY | WHEN | EFFECTS |
|--------|------|---------|
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Have you had a transfusion? Y / N If yes give date: _____

Are there any preceding conditions after which you have never felt totally well again? Y / N If yes explain: _____

What immunizations have you had? _____

Any adverse effects from them? _____

Any prolonged courses of antibiotics? _____ Why? _____

Any adverse effects? _____

Have you lost weight lately? _____ How many pounds? _____

Present weight: _____

What exercise do you do and how much? _____

Any dental problems now? _____

Do you use Tobacco? Y /N If yes how much daily? _____

Do you drink alcohol? Y /N If yes how much daily? _____

Do you drink coffee? Y /N If yes how much daily? _____

Are you currently under the care of another Physician(s)? Y /N If yes please list them and why you are seeing them _____

Have you been treated with Homeopathy before? Y /N If yes, by whom _____

Family History : Place an (X) in the appropriate columns for any illnesses that you or your relatives have had.

| Illness | Self | Father | Mother | Brother | Sister | Child | Grandparent |
|---------------|------|--------|--------|---------|--------|-------|-------------|
| Abscesses | | | | | | | |
| Alcohol/Drugs | | | | | | | |
| Allergies | | | | | | | |
| Anemia | | | | | | | |
| Arthritis | | | | | | | |
| Asthma | | | | | | | |
| Autism | | | | | | | |
| Cancer | | | | | | | |
| Depression | | | | | | | |
| Diabetes | | | | | | | |
| Eczema | | | | | | | |
| Emphysema | | | | | | | |
| Epilepsy | | | | | | | |
| Frequent | | | | | | | |

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|---------------------|--|--|--|--|--|--|--|
| Infections | | | | | | | |
| Heart Disease | | | | | | | |
| Hepatitis | | | | | | | |
| High Blood Pressure | | | | | | | |
| Kidney Problems | | | | | | | |
| Mental Illness | | | | | | | |
| Migraines | | | | | | | |
| Prostate Issues | | | | | | | |
| Pneumonia | | | | | | | |
| Polyarthritis | | | | | | | |
| Psoriasis | | | | | | | |
| Rheumatic Fever | | | | | | | |
| Stomach Problems | | | | | | | |
| Stroke | | | | | | | |
| Thyroid Issues | | | | | | | |
| Tuberculosis | | | | | | | |
| Ulcers | | | | | | | |
| Venereal Disease | | | | | | | |
| Warts | | | | | | | |
| Weight Issues | | | | | | | |
| Skin Cancer | | | | | | | |
| Parasites | | | | | | | |
| STDs | | | | | | | |
| Measles | | | | | | | |
| Mono | | | | | | | |
| Worms | | | | | | | |
| Gall Stones | | | | | | | |

INDICATE BELOW AGE OF BLOOD RELATIVES AND ANY AILMENTS THEY MAY HAVE. Such as cancer, asthma, allergies, etc.

| Relative | Age if Alive | Age at death | Ailments |
|----------------------|--------------|--------------|----------|
| Mother | | | |
| Father | | | |
| Maternal Grandmother | | | |
| Maternal Grandfather | | | |
| Paternal Grandmother | | | |
| Paternal Grandfather | | | |

“I _____ have received a copy of Dr Bekkers’ **Notice of Privacy Practices**” Signature : _____ Date: _____