

**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

**LIST ANY ALLERGIES**


**MAJOR COMPLAINTS**

COMPLAINT	SINCE	CAUSE

**LIST ANY TREATMENT/REGIMES YOU ARE FOLLOWING**

TREATMENT	SINCE	RESULTS

**LIST ANY OPERATIONS YOU HAVE HAD**

OPERATION	WHEN	COMPLAINTS

## LIST ANY MAJOR INJURIES

INJURY	WHEN	EFFECTS

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 \_\_\_\_\_

### For Women Only:

Age of First menses: \_\_\_\_\_      First day of last menses: \_\_\_\_\_

Menses are regular: Y / N

Number of Pregnancies: \_\_\_\_\_      Number of Miscarriages: \_\_\_\_\_

Are you using Birth Control? Y / N    if yes what kind? \_\_\_\_\_

**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
Abnormal Periods							
Abscesses							
Alcohol/Drugs							
Allergies							
Anemia							
Arthritis							
Asthma							
Autism							
Bleeding Problems							
Cancer							
Depression							

Diabetes							
Eczema							
Emphysema							
Epilepsy							
Frequent Infections							
Heart Disease							
Hepatitis							
High Blood Pressure							
Kidney Problems							
Mental Illness							
Migraines							
Miscarriage							
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: \_\_\_\_\_