INFORMATION FOR YOUR PHYSICIAN

DATE:

NAME:	DATE OF BIRTH:
ADDRESS:	HOME PHONE:
CITY, STATE, ZIP:	CELL PHONE:
SEX: M F NUMBER OF SIBLINGS:	
EMERGENCY CONTACT:	PHONE NUMBER:
REFERRED BY:	
EMAIL:	
PARENTS NAMES:	
PEDIATRICIAN:	
CURRENT SCHOOL:	

LIST MEDICATIONS THEY ARE CURRENTLY TAKING

MEDICATION	SINCE	EFFECTS

LIST ANY ALLERGIES

MAJOR COMPLAINTS

COMPLAINT	SINCE	CAUSE

LIST ANY TREATMENT/REGIMES THEY ARE FOLLOWING

TREATMENT	SINCE	RESULTS

LIST ANY OPERATIONS THEY HAVE HAD

OPERATION	WHEN	COMPLAINTS

LIST ANY MAJOR INJURIES

INJURY	WHEN	EFFECTS

BIRTH HISTORY

INCLUDE BIRTH WEIGHT, PROBLEMS DURING PREGNANCY OR AFTER BIRTH

Have they had a transfusion? Y / N If yes give date:____________________
Are there any preceding conditions after which they have never felt totally well again? Y / N If yes explain:____
____
What immunizations have they had? ______________________________________
____
Any adverse effects from them? ____
Any prolonged courses of antibiotics? _____ Why?_______________________
Any adverse effects? ____
Have they lost weight lately?_______ How many pounds? ______
Present weight:_______
What exercise do they do and how much? ________________________________
____
Any dental problems now?____
Does your child use Tobacco? Y /N If yes how much daily?_________________
Does your child drink alcohol? Y /N If yes how much daily? _________________
Does your child drink coffee? Y /N If yes how much daily? _________________
Are they currently under the care of another Physician(s)? Y /N If yes please list them and why you are seeing them ______________________________________

Have they 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
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							
Prostate Issues							
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:_________