Nicole Ramos Classical Homeopathy 3566 Harding Avenue, Suite 202 Honolulu, HI 96816. 818-212-9673

PATIENT HISTORY

Full Name

First Name Last Name

Date

Month Day Year

Pronouns:

What is your age?

What is your gender?

Please Select

Contact Number

Email Address

example@example.com

Occupation:

Education:

Referred by:

Diet?

- ○ Non-Vegetarian
- ○ Vegan
- ○ Vegetarian
- ○ Other

PREVIOUS DISEASES AND MEDICATIONS USED: Every disease poisoning or accident leaves its mark and remains as a weak point in the system, much more than we imagine. Homeopathic treatment takes into account all of these details of the past and removes all the weak points, thus your body is strengthened. That is why it is necessary for us to know about all the ailments you have suffered from in the past and the treatments you have taken.

- ☐ Typhoid
- ☐ Cholera
- ☐ Food Poisoning
- ☐ Malnutrition
- ☐ STI
- ☐ German Measles
- ☐ Smallpox
- ☐ Whooping Cough
- ☐ Syphilis
- ☐ Jaundice
- ☐ Spleen Disease
- ☐ Heart Problems
- ☐ Fainting
- ☐ Abortion
- ☐ Illness in Pregnancy
- ☐ Bladder Problems
- ☐ Prostate Problems
- ☐ Dysentery
- ☐ Diarrhea
- ☐ Worms
- ☐ Rickets
- ☐ Measles
- ☐ Chickenpox
- ☐ Mumps
- ☐ Gonorrhea
- ☐ Malaria
- ☐ Liver Disease
- ☐ Gall Bladder Disease
- ☐ High Blood Pressure
- ☐ Miscarriage
- ☐ Uterine Prolapse
- ☐ Kidney Problems
- ☐ Diabetes
- ☐ Other

Surgeries:

- ☐ Tonsils
- ☐ Kidney Stones
- ☐ Gallstones
- ☐ Reproductive Organs
- ☐ Hemorrhoids
- ☐ Cataract
- ☐ Anesthesia Local/General
- ☐ Hernia
- ☐

☐

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Other Conditions:

☐ Chronic Headaches
☐ Polio
☐ Diptheria
☐ Lumbar
☐ Other

☐ Tuberculosis
☐ Numbness
☐ Paralysis
☐ Asthma

☐ Infected Tonsils
☐ Other Conditions
☐ Cramps
☐ Depression

☐ Meningitis
☐ Pneumonia
☐ Seizures
☐ Anxiety

Skin Diseases:

☐ Ance
☐ Urticaria
☐ Seizures

☐ Scabies
☐ Pneumonia
☐ Pimples

☐ Carbuncles
☐ Ulcers
☐ Herpes

☐ eczema
☐ Boils
☐ Other

	Disease Suffered From:	Age:	Duration	Complete Recovery	Treatment Including Other Medications	Other Details
1A						
1B						
1C.						

Extra Remarks or Information

Immunizations

	Smallpox	Polio	Cholera	Measles	DPT	BCG	Typhoid	Tetanus	Hepatitis	Hib	OTHER:
Number Of Times											

Was there any reaction or particular problems after any of the above immunizations?

Number of children living and/or deceased (please state cause of deceased):

Childs's Name	Sex (M/F)	Age	Past and Present Illnesses

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Any abortions, miscarriages or stillbirths?

How is the health of your spouse/partner?

Any major accident or injury to the body or head?

Any occasion of unconsciousness?

Any hemorrhage or major bleeding from any part of the body?

Any serious shock, grief, disappointments, fright, mental upset, depression or nervous breakdown? Please explain.

Personal Habits, past and present:

	How Much	How often
Substances:		
Alcohol		
Tea/Coffee		
Sleeping Pills		
Laxtives		
Marijuana		

Other:

Any other information or remarks: