STRICTLY CONFIDENTIAL
HEALTH QUESTIONNAIRE FOR HOMEOPATHIC TREATMENT (MALE)

Dr. Benjamin J. Herr
M. Tech. Hom
Registered Dispensing Homeopathic Doctor

EMAIL: info@ homeopathycapetown.co.za
WEBSITE: www.homeopathycapetown.co.za
OFFICE: 021 674 4476
CELL: 083 258 3728

STRICTLY CONFIDENTIAL (MALE)

First Name:		Gender:	MALE
Middle Name(s):		Age:	
Surname:		Date of Birth:	
Occupation:		Weight:	
		Height:	

PLEASE READ THROUGH ENTIRE QUESTIONAIRE BEFORE ANSWERING!

When answering, please note that it is in your best interests to give as much detail as possible, the more accurate and complete the information given the better I am able to help you.

Please describe pains as fully as possible, using words such as:

sharp, dull, jerking, boring, tearing, burning, bursting, pulsating, constricting, cramping, numb, numb yet with pain, cold, etc…

If pain moves from one part to another - name the parts/describe. Give the sensations in your own language no matter how simple, or even ludicrous. State what makes the pain ***better*** or ***worse*** - such as:

pressure, movement, rest, seated, standing, walking, heat, cold, food, sea-air, coition, time of day, time of year, bathing, taking a very hot shower, etc...

AS FAR AS POSSIBLE, PLEASE GIVE YOUR OWN UNIQUE *DESCRIPTION* IN YOUR REPLY, THE IMPORTANCE OF THE INFORMATION YOU GIVE IS IN THE *INDIVIDUALITY* OF YOURSELF AND NOT JUST A YES OR NO ANSWER.

		ANSWER
1	Colour of Eyes?	
	Hair:	
	Complexion:	
	Relationship status:	Single / partner / married / widowed / divorced

2 **Describe** your **MAIN COMPLAINT(S):**

When did it begin?
What makes it better or worse?
When is it better or worse?
What do you think caused it?
What other symptoms may accompany this main complaint?

3 **HEAD:** Describe pains and give their location - on top, back, front or side, etc.	

4 **EYES:** Describe pain, defect of vision, defect of eye or any troubles, etc.	

5 **NOSE:** Describe catarrh, colour, watery, thick, plugs, burning, sneezing, allergies, any sinus pain / blockage, etc.	

6 **EARS:** Describe pains, deafness, noises, itching, discharge, etc.	

7 **MOUTH:** Describe condition of teeth, colour of tongue, peculiar taste?	
Tonsils/Lips, DESCRIBE:	
Are you thirsty?	
Do you crave anything to drink? What?	
What temperature do you like it? e.g. ice cold	
How much cold liquid per day do you drink?	
How much hot liquid per day do you drink?	How much sugar per cup?

8 **THROAT:** Any difficulty swallowing, pain, on left or right side, better or worse when swallowing liquids / food?	

9 **CHEST:** Describe pain, palpitation, breathlessness, sensations, cough, sputum, need for open windows, asthma? What make it better / worse? Any change through the day / night?	

10 **STOMACH:** Describe pains, nausea, vomiting, flatulence, etc…	
Foods you crave:	
Foods that disagree:	
Are symptoms better/worse after eating? How long after?	

11 **DIET:** Please describe you last 24 hours meals in detail. (What, how much, how it was prepared, etc.)	
Breakfast:	
Snack:	
Lunch:	
Snack:	
Dinner:	

12 **STOOLS:** How frequently do you pass a stool? Describe if: hard/watery/mixed with blood/mucus/ fat/undigested food, etc. colour, unusual smell? Describe constipation / laxatives use… Do piles bleed or protrude? Any discharge? Is there pain/itch, skin raw, inflamed?	

13 **URINE:** If painful, burning, frequent, involuntary/difficult. If there is pressure, sediment, odour, retention - give colour.	
Do you go at night? What time/s?	

14 **MALE GENITALIA:** Describe any pain, itch, discharge, swelling, skin eruptions etc.	
How would you describe your sex drive?	
No pain/difficulty with erection, early or late ejaculation?	
History of illness in this area:	

15 **BACK:** Position of pain in shoulder, back, waist, seat or spine, better or worse for…?	

16 **LIMBS:** If pain, is it in: muscle, nerve, joint or skin & exact location – better / worse for movement/rubbing / weather changes etc.	

17 **SKIN:** If rough, itching, burning, dry or moist. Describe any strange sensations, eruption, rashes, inflammation, odour or peeling. State parts affected.	

18 **PERSPIRATION:** Do you - at all?	
If so, where do you start perspiring from?	
And when exactly? Does it smell? A lot?	
Does it discolour clothing? What colour?	

19 **GENERAL:** Do you feel better:	
Indoors or outdoors?	
In cool air or a warm room?	
When resting or moving about?	
At night or during the day? Time?	
In Summer/Autumn/Winter/Spring?	
When hot/cold? Wet/dry weather?	
At the seaside or inland/mountains?	
Describe your weekly physical exercise.	

20 **SLEEP:** If restless, disturbed.	
When you waken - what time/s?	
What wakens you? Is it pain, worry, emotion, excitement, dreams?	
Are your troubles better or worse at night?	
What position do you sleep in?	
What do you dream about?	

21	**MENTAL SYMPTOMS:** *The symptoms of the Mind and Disposition **ARE MOST IMPORTANT** and should be carefully considered and reported. Give this section your particular thought.*

How would you describe yourself?

Describe your hopes, dreams, desires and ***fears***:

What do you spend most of your time thinking about / to what do your thoughts tend to gravitate around?

What is your favourite activity?

What is the most important aspect of your life and why?

Describe **5 positive** characteristics AND **5 negative** characteristics about yourself:

If you could change one thing about yourself what would that be and why?

What traits do you like the least in ***others***?

Are there any observations that others close to you have commented on about you?

How would you describe your emotional state?

What is your religious belief?

What role does this play in your life?

22	**Biography of your life:** (give a description of the important/significant/recurrent events in your life since birth to date.)

23	Have you suffered from any of the following?					
Rheumatic fevers		Scarlet fevers		Glandular fever		
Typhoid		Cholera		Bilharzias		
Malaria OR prophylaxis		Mumps		Tumours / Cancer		
Diabetes		Measles		Whooping Cough		
Bronchitis		Pneumonia		Heart Disease		
Sinusitis		Hepatitis		Yellow Jaundice		

X-ray, MRI, CT or Radium/Cobalt Treatments?	
When last were you immunized?	
List all immunization received?	
Do you smoke? For how long and how many?	
Do you drink Alcohol? How much and for how long?	
Describe any operations &/or accidents.	
Is your food cooked in aluminium pots?	
List & date all destinations travelled to recently & in the past: (Outside the Western Cape)	

24 **ALL CURRENT MEDICATION & SUPPLEMENTS:** *Please list full name and dosage:*

25	**Family Medical & Social History:** (Please also include any major family problems/issues)
Mother:	
Mother's Mother:	
Mother's Father:	
Father:	
Father's Mother:	
Father's Father:	

26 **ANY COMMENTS YOU MAY WISH TO ADD:**