VATSALA SPERLING
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ROCHESTER
HOMEOPATHY
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1. Patient Information

Name: _____

Address: _____

_____

City: _____ State: _____ Zip Code: _____

Age: _____ Date of Birth: _____ Spouse: _____

Home phone: _____ E-mail: _____

Occupation: _____ Employer: _____

Work Address: _____ City: _____ State: _____ Zip Code: _____

Emergency Contact: _____

Relationship: _____ Phone:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Referred by: _____

2. What is the main reason for today's visit? _____

_____

Secondary reasons? _____

_____

Please name other doctor(s) consulted? _____

Phone:_____ Diagnosis? _____

_____

3. Please check conditions which you have presently or have had in the past *(if possible, also incidate approximate date of onset)*.

Allergies (food) _____	Kidney disease _____	Arthritis _____
Allergies (environment) _____	Urinary tract disease _____	Backache _____
Asthma _____	Heart disease _____	Muscle/Joint problem _____
Bronchitis _____	Stroke _____	Numbness/tingling _____
Cough/sneeze _____	High/Low blood pressure _____	Skin disorder _____
Pneumonia _____	Anemia _____	Frequent infection _____
Sinusitis _____	Varicose veins _____	Frequent fevers _____
Tuberculosis _____	Headaches _____	Fatigue _____
Dental problems _____	Eye/Vision problems _____	Weakness _____
Constipation _____	Ear/Hearing disorders _____	Cold/Heat sensitive _____
Diarrhea _____	Dizzyness _____	Addiction _____
Gallbladder disease _____	Seizures _____	Poisoning _____
Heartburn _____	Head injury _____	Mumps _____
Hemorrhoids _____	Nervous disorder _____	Measles _____
Indigestion _____	Memory problems _____	Rubella _____
Liver disease _____	Thyroid disorder _____	Chickenpox _____
Nausea _____	Sleep disorder _____	Whooping cough _____
Odd Appetite _____	Odd sweating _____	Polio _____
Odd thirst _____	Genital disorder _____	Mononucleosis _____
Ulcer _____	Venereal disease _____	Rheumatic fever _____

Are there any other conditions not listed above? _____

_____

Are you easily susceptible to stress, anxiety or irritability? _____

_____

Have you experienced any traumas or grief? _____

_____

4. Please list history of surgery or hospitalizations with approximate dates. _____

_____

5. Have you had any of the following immunizations?

Polio _____ Measles _____ Rubella _____ Mumps _____

Smallpox _____ Diptheria/Pertussis/Tetanus (DPT) _____ Other _____

Have you ever had any adverse reaction to an immunization? _____

6. Are you taking any medications, nutritional supplements or herbs? ***If so, please list the name, purpose, and dosage.*** _____

_____

_____

7. Do you drink coffee, consume alcohol, or smoke cigarettes? ***If so, please list how much.***

_____

_____

8. Do you have any special diet or dietary restrictions? _____

_____

_____

9. Do you have any sexual difficulties? _____

_____

10. Gynecological history:

Menses began at age	_____	Number of pregnancies	_____	Duration of flow	_____
Menopause began at age	_____	Number of		Number of live births	_____
Length of cycle	_____	miscarriages/stillbirths	_____	Number of abortions	_____

Do you have any menstrual irregularities or premenstrual symptoms? _____

_____

Do you have a history of irregular PAP tests, unusual bleeding, or discharge? _____

_____

Do you have a history of unusual pregnancies or difficulty being pregnant? _____

_____

Is there any other relevant information? _____

_____

11. Dental history:

How many fillings do you have? _____ What is the filling material? _____

How many root canals do you have? _____

Other dental problems _____

_____

12. Family history:

Diabetes	_____	Heart disease	_____	Skin problems	_____
Arthritis	_____	High blood pressure	_____	Headache/migraines	_____
Asthma	_____	Neurological disease	_____	Thyroid problem	_____
Tuberculosis	_____	Alcoholism/addictions	_____	Cancer	_____

Other conditions not listed above _____

_____

_____

_____

I agree that to the best of my knowledge and belief, the above information is complete and accurate.

Signature _____ **Date** _____