New Patient Questionnaire

Please complete this questionnaire as thoroughly as you can and bring it with you to your first appointment.

Full name:	Date of birth:
Address: Postcode:	Home Tel: Mobile: E-mail:
GP Name: Surgery address: Telephone:	
Referred by: Family / Friend / G.P. / Advert / Other - Please specify	
I confirm that I have requested homeopathic treatment Signed: Date:	
I consent to being contacted by ☐ Email ☐ Text message ☐ Phone	
Briefly describe the condition(s) you would like me to help you with	
Details of current medication/drugs	
Details of alternative therapies/vitamins/supplements	

Details of previous medication/drugs
Allergies, past and present
Vaccinations and any reactions
Please provide details of close relatives' illnesses, including heart problems, cancer, diabetes, degenerative conditions, tuberculosis, mental health problems, asthma, eczema, hay fever, etc.

Mother	Father
Grandmother	Grandmother
Grandfather	Grandfather
Aunts	Aunts
Uncles	Uncles
Cousins	Cousins
Siblings	
Your children	

Your history

	Age	
Pre-birth: Any emotional or physical problems experienced by your mother during pregnancy, or medication		
Birth: Type of labour, delivery, medication. Breastfed or bottle fed		
Illnesses: Measles, mumps, chicken pox, German measles, scarlet fever, glandular fever, rheumatic fever, tonsillitis, dipthereria, recurrent colds, ear problems, whooping cough, tuberculosis etc		
Accidents: Note any accidents, serious or minor		
Surgical procedures or major dental works including medication and anaesthetic used		
Shocks/Traumas: Anything which may have impacted on your mental, emotional or physical wellbeing		