MedHints

Charitable Medical Research Trust
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For your charities
Account Name: MedHints,
Account Number: 35896771031,
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Bank: SBI, Richards Town, Bengaluru, 560005

Case Taking Questionnaire

Medical Profile of: _____

Medical homeopathic international society (MedHints)
Elegant Splendour, 4th Floor, #405, 7th A Main, HRBR Layout, 1St Block, Kalyan Nagar, Bengaluru – 5600043
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PLEASE READ THIS FIRST BEFORE FILLING THIS FORM

To select the best possible medicine to help you, doctor depends on your good co-operation. HOMOEOPATHIC MEDICINE IS MAINLY SELECTED ON THE SYMPTOMS. To make a successful prescription (healing medicine), doctor must know all the details of your sickness. Doctor must also understand your reactions to various factors as you are individual, your past and family history and your state of mind and likes and dislikes. Well selected Homeopathic remedy heal your sickness and makes you well as a whole person. In order find all about you, doctor need to ask many questions. Each one of these questions has a definite meaning and significance in Homeopathy. There is not a single question that is useless. Even something that you may think is not connected with your trouble, may be the most important factor in deciding the correct homoeopathic medicine. *That is why you must be free and frank and give the fullest possible information on each point*. Please read each question carefully, think, and if necessary, consult someone close to you and then answer completely. Do not keep anything back. Remember, whatever you tell will be kept absolutely confidential. Doctor works in the interest of you and in welfare of you.

THIS QUESTIONNAIRE HAS 8 PARTS:

- About your past illnesses. Please take time to answer this part with the help of your family members before coming to us.
- History of your present illness.
- About all the parts of your body.
- Deals with the factors that affect your health. Please think carefully about each of the factors mentioned and write what specific effects they have on you.
- About your state of mind and your emotional nature. Please write in this part about your situation in life and about all the things that are bothering you. Be open to discuss.
- About your sleep and dreams.
- how you were as a child.
- In this part you are given instructions on how to report each of your complaints. Read the instructions first. Then make a list of your complaints and describe each of them according to the instructions.

PERSONAL DETAILS:

Date :

Name : _____

(Begin with Surname)

Address :

Telephone: Residence: Office:

Mobile :

E-mail :

Age: Sex: Male / Female

Date of Birth:

Vegetarian / Non-Veg. / Egg. Veg. Single/Married/Divorced/Widowed

Occupation (Nature of Work) : Education :

Referred by:

HOW TO DESCRIBE YOUR COMPLAINTS

In homoeopathy, prescription is based on precise details of various symptoms from which you suffer. To tell or write to a homoeopathic physician "I have a headache", "an eruption", or "cough", would not be enough. If you inform him "I have headache with sharp shooting pains in the left side of the head and temple, these pains always come on when the slightest cold air strikes the head, the pains are much less when lying down and covering up the head warmly and much worse when rising up, walking about or when the head becomes cool", then only you have given all the information required for making a good homoeopathic prescription.
The success of the prescription depends, largely, on how detailed is your description of the symptoms.

We require the following details about your symptoms.

LOCATION : Please give the exact location of sensation, pain or eruption. Also describe where the pain or sensation spreads. Please use the figure on page 24 to indicate location.

SENSATION : Express the type of sensation or the pain that you get in your own words however simple or funny it may seem. You may have a sensation that a mouse is crawling or the heart was grasped by an iron hand or you may have a pain which is cutting, burning, jerking, pressing. Express the sensation or pain as it feels to you.

WHAT MAKES YOU WORSE OR BETTER: Many factors are likely to influence your trouble. Some factors may cause the trouble to increase and some factors may relieve the trouble. A detailed list of the factors is given on pages 14 to 16. Please refer to them when describing each of your troubles and indicate which factors make the complaint better or worse.

DISCHARGES: You may have a discharge from ulcers, fistula, eruptions the skin, lungs, eyes, nose, ears, mouth, private parts, etc. Please describe your discharge under the following aspects.

- The quantity and the time or condition under which the quantity varies i.e. when is it better or worse, increases or decreases?
- The consistency; Is it thin or thick, stringy, or clotted?
- Is it like jelly, white of an egg, like water, sticky, forming a scab etc.?
- The odour, what does it remind you of?
- Does it make the parts sore, and in what way?

Your Present main complaints and other associated troubles: (and detailed history of the present illness, the onset and course with dates)

Origin of cause: can you trace the origin of the present illness to any particular circumstance, accident, illness, incident or mental upset? (e.g. Shock, worry, errors in diet, overexertion, overexposure to cold, heat etc.)?

PLEASE DESCRIBE EACH OF YOUR PHYSICAL COMPLAINTS IN DETAIL

S.No	WHERE IS THE TROUBLE	WHAT EXACTLY DO YOU FEEL OR HAVE THERE	WHAT ARE THE FACTORS THAT MAKE THIS TROUBLE BETTER OR WORSE?

How are these health issues are affecting your life in general / Globally in which areas of your life?

APPETITE AND THIRST

How is your appetite?

When are you hungry?

What happens if you must remain hungry for long?

How fast do you eat? (either by time or compared to others)

How much thirst do you have?

Any particular time are you specifically thirsty?

Do you feel any change in your taste and feeling in your mouth?

Please put one tick (✓) if you Like/ Dislike the food or if the food disagrees. Put two marks (✓✓) , if you strongly Like / Dislike the food or if the food strongly disagrees.

Food	Like	Dislike	Disagree
Bitter			
Salt extra			
Sweet			
Sour			
Bread			
Butter			

Fats			
Milk			
Coffee			
Mud / Chalk			
Eggs			
Spicy food			
Meat			
Fish			
Cabbage			
Onions			
Warm food / drink			
Cold food / drink			
Fruits			
Anything else			

STOOL Related

Do you have any problem regarding your stools?

When and how many times a day you pass stools?

When is it urgent?

Do you have any problem about bowel movements?

Do you have to strain for stool? Even if soft?

Do you have belching or passing gas? Describe its character.

How do you feel after passing gas up or down?

URINATION & URINE

Any problem about urine?

Any strong smell? Like what?

Do you have any trouble before, during and after passing urine?

Any difficulty about the flow? Slow to start, interrupted, feeble, dribbling etc.?

Any involuntary urination ? When?

SWEAT / PERSPIRATION - FEVER - CHILL

How much do you sweat/Perspiration?

Where and on what part do you sweat most?

Do you perspire on the palms or soles?

Is the sweat warm, cold, clammy, sticky, musty, greasy, stiffens the linen etc.?

What is the smell like? e.g. foul, pungent, sour, urinous.

What colour does it stain the clothing?

Is the stain easy to wash off or difficult?

Any symptoms after sweating?

When do you get fever or chill?

What brings it on?

Do you experience any sense of heat or cold in any part of your body at any particular time?

Do you have burning or heat in your palms or soles?

CHEST - HEAT - COLD - COUGH

Do you catch cold often? If so, how?

Describe the symptoms, nature of discharge etc.

Is there any trouble with your CHEST or HEART?

Is there any trouble with your voice or speech?

Is there any difficulty in breathing?

Do you have cough?

Is it more at any particular time?

SEXUAL SPHERE (GENERAL)

Any excessive indulgence in sex in past and present?

Any effect on your health?

How do you feel after sexual intercourse?

Any particular feeling or symtoms appear before, during or after sexual intercourse?

Do you suffer from any sexual disturbance?

Any habit like (masturbation etc.) in past

as well as present? How often?

Any homosexual inclination?

Did you suffer from any sexually transmitted disease ?

Syphilis ? Gonorrhoea ? Herpes ? HIV ?

Did you have increased desire or decreased desire for sex ?

What is the method you use for family planning (contraception) ?

FOR MEN

Any difficulty in erection ?

Wanted erection ? Unwanted erection ?

Weak erection ? Failing erection? Describe.

Any other trouble in sex ? Describe in details.

FOR WOMEN

Menses : How are the periods; regular or irregular ?

At what age did you start?

Was there any trouble then?

Mention interval between two periods.

Mention number of days of flow.

Menstrual flow: Is there any change now in quantity, colour, smell or consistency?

Are the stains difficult to wash?

Have you noticed any variation in quality and quantity of flow during menses? How and when?

Do you suffer in any way before, during or after menses ? If so, describe :

What symptoms did you suffer during menopause?

Do you feel internal parts coming down (bearing down)?

Is there any white discharge?

If so, mention the nature, colour, consistency and smell of discharge. When and under what circumstances is it more or less.?

Has the discharge any relation to menses ?

What is the effect of this discharge on your general feeling? Or any of your symptoms?

Any itching, excoriation etc. due to discharge?

Do you pass any gas from vagina?

Any trouble with breasts?

ANY COMPLAINTS ABOUT:

VERTIGO - Do you have giddiness - vertigo?

Faintness: Do you ever feel faint?

HEAD: Do you get headaches?

EYES & VISION:

EARS & Sense of hearing:

NOSE & Sense of smell:

FACE & Facial expression:

MOUTH & Sense of taste:

About LIPS, MOUTH, TONGUE etc.:

TEETH, GUMS, e.g. carious teeth, bleeding gums., swollen gums.

LIPS : Cracked, peeling of skin etc.

THROAT (including tonsils) :

Any difficulty in swallowing?

Do you have any trouble in your BACK, LIMBS

OR JOINTS? Describe in detail :

If you have pains, do they shift ?

In what direction do they extend ?

Is there any abnormality, swelling, numbness,

paralysis etc. in any part of the body ?

Is there any complaint of SKIN : such as itching, eruptions ulcers, warts, corns,

peeling etc.? (Describe its nature)

Any change in colour of the skin or

spots of any part of the body?

Is there any complaint or abnormality of the NAILS or skins around?

Is there any complaint with the HAIR such as falling, greying, dandruff, dryness, oily , poor excessive or unusual growth ?

Do wounds heal slowly?

Form keloid? Do wounds tend to form pus?

Have you a tendency to bleed?

Are your troubles one sided? which one?

Or more on one side?

Do they proceed from one to the other side?

Or do they alternate or shift?

Is there any trembling? When?

Is there any senses of weakness? Where?

When is it more or less?

Is it in any particular part of the body?

FACTORS THAT AFFECT YOU

Below are the list of things that you are exposed to each of these factors may affect you in a particular way. Please write in what way you are affected by each of the following. Do you feel worse or better in any way from each of the factors. In what way do they affect you. For instance, take the factor “sun”. Suppose by going in the sun you get a headache then write

“Headache” opposite to “Sun”. Take another example if in hot weather you feel uneasy, then write “Uneasy” opposite to “Hot Weather” in the column.

In this way write the effect of each factor on you. Especially write the effect each factor has on your main complaints. For instance if your main complaint is Asthma and this is worse when lying on the back then opposite to “lying on the back” write “Asthma becomes worse”.

Sometimes one factor may make you feel worse in some respect, and better in some other respect. For instance, cold air may cause headache but make you feel better in general. If this is so, please describe this difference clearly.

This section is most important. Do not go through it hurriedly. Think carefully about the effect of each factor before you write.

Exiting Factor	**Effect**	**Exiting Factor**	**Effect**
Hot weather		Walking	
Cold weather		Running	
Rainy weather		Climbing stairs	
Cloudy weather		Going downstairs	
Change of season		Riding in bus, car etc.	
Thunder – storm		Lying	
Covering		Lying on back	
Warm bath		Lying on left side	
Sun		Lying on right side	
Cold bathing		Lying on abdomen	
Lying with head Low		Drinking	
Sitting		After sexual intercourse	
Sitting erect		Dust	
Standing		Smoke	
Looking up		Touch	
Looking down		Pressure	
Looking from high places		Massage	
Looking from moving object		Tight Clothes	
Noise		Before Sleep	
Sudden Noise		During Sleep	
Music		After Sleep	
Light		After afternoon nap	
Strong smells		Loss of sleep	
When constipated		Before stools	

Before Urine		During stools	
During Urine		After stools	
After Urine		Coughing	
Before Menses		Sneezing	
During Menses		Laughing	
After Menses		Talking	
After Sweating		Reading	
When Fasting		Writing	
After eating		Stooping	
Before important		Passing gas	
Engagement		After hair cut	
Before exams		Combing hair	
When angry		Brushing teeth	
When worried		Moonlight	
When sad		Opening the mouth	
After Weeping		Smoking	
Consolation / Sympathy		Hanging the limbs	
In a crowd		Raising the arms	
In a closed room		Near Sea	
When thinking of illness		Shaving	
Full Moon / New Moon		Stretching	
Morning		Swallowing	
Afternoon		Listening to others	
Evening		talk	
Night		Vomiting	
Bathing		Yawning	
Draft air		Moving the eyes	
Biting or chewing		Opening the eyes	
Blowing Nose		Closing the eyes	
When alone		Getting feet wet	
In company		Over eating	
Physical exertion		Working in water	
Belching		Fanning	

Please write your understanding about the above Effect on your body

MIND

It is now universally acknowledged that your mind has tremendous influence on your body. For giving proper treatment it is absolutely necessary for us to understand your emotional and intellectual nature. We can thus treat you as a whole. In order to understand you we will be asking certain questions. Answer them freely, carefully and completely. This information will help us much in giving you the correct remedy. Also such a remedy will help improve your mental make up.

Answer freely. Answer frankly. Answer completely.

Are you anxious? About which matters?

Are you fearful of anything such as animals, people, being alone, darkness, death, disease,

robbers, sudden noises, thunder, of the future, of something unknown, high places, etc. ?

Are you doubtful or suspicious? Of what?

what are you jealous about?

Of whom? From what symptoms do you suffer when jealousy?

In which matter are you impatient? Hurried?

How long do you remember hurts caused to you by others ?

How much revengeful are you?

What are you proud of? Does your pride get easily hurt?

Depress, Brooding, etc.?

Do you ever become suicidal? When?

If so in what manner do you contemplate to end your life?

Even then, are you afraid of dying?

When are you cheerful ?

Are you sexual-minded ?

Any unwanted thoughts any time ?

What are they ?

Have you any imaginary sensations or fears ?

Do you hear voices, or that you are called, or anything else in this line keeps on occurring in your mind unduly?

How is your memory?

For what is it poor? e.g. names, places, faces, what you have read, etc.

Do you weep easily?

What makes you weep?

How do you feel after weeping?

How do you feel if someone offers sympathy and consolation?

Are you easily irritated?

What makes you angry?

What bodily symptoms do you develop when angry? e.g. trembling, sweating etc.

Do you like company? Or like to remain alone?

How seriously are you affected by disorder and uncleanliness in your surrounding?

What are the greatest griefs that you have gone through in your life?

What are the greatest joys that you have had in life?

What activities you deeply like?

Are there any matters which you deeply dislike?

In your opinion, which aspects of your mind and moods are not agreeable to you. Inspite of your awareness and maturity, are you unable to change these aspects ?

Give a clear cut picture of your situation in life and your relationship with each of your family members, friends and associates in work.

How does the future look to you?

When you are free, what thoughts come to your mind?

Are you worried or unhappy over any personal, domestic, economical, social or any other condition? If so describe in detail:

If asked for 3 desires or wishes in life, what will you ask for?

SLEEP

Describe your posture in sleep, on the back, side, abdomen etc.

Are you able to sleep in any position?

In which position you can't sleep?

During sleep do you:

Snore? Grinding teeth?

Dribble saliva? Sweat?

Keep eyes or mouth open?

Walk? Talk? Moan? Weep?

Become restless? Wake up with a jerk?

Describe if anything else is unusual about your sleep: (Sleepy, Sleeplessness, etc. if so when)

How much do you cover?

Do you have to uncover any parts?

Circle types of dream that you have

Animals Cats – Dogs Horse Wild animals Snakes	Robbers Thieves Anxious Fearful Ghosts	Travelling Riding Flying Swimming Drowning	Houses Fruits Trees Water Snow
Death, Whose? Dead bodies Dead persons Part of Body	Being Hungry Being Thirsty Drinking Eating	Fire Lightning Storm Rain	Accidents Falling Shooting Wars

Suicide			
Talking Singing Dancing Pleasant	Business Money Day's work Forgotten work	Vomiting Passing stool Urinating Blood-bleeding Excrements /soiling	Romantic Sexual Pleasure Rape Nakedness
Pain Illness Sickness Mutilations	Praying Religious Temple Church God	Failure / Exams Unsuccesful efforts ? For what ? Missing Train Being unprepared	Grief Weeping Vexation Quarrels Jealousy Insults
Police Imprisonment Crime Murder Killing Poison	Misfortunes Insecurity Danger Being pursued - By whom? - For what?	Of people Children Parties Feasts Marriage	Of events Remote Recent Future Prophetic
Physical Exertion Mental Exertion Fatigue	Coloured Multi-Coloured		

If any other, specify below:

PREVIOUS DISEASES & DRUG USED

Every disease, drug, poisoning, or accident leaves its mark and remains as a weak point in the system, much more than we imagine. Homoeopathic treatment takes into account all these details of the past to correlate and understand the system in holistic way. Hence, it is necessary for us to know about all the ailments you have suffered from in the past and the treatments you have taken.

In the list below, circle around names of ALL major illness so far suffered and on the next page give its relevant details.

Typhoid Cholera Food poisoning Worms Diarrhea Dysentery	Whooping cough Measles German Measles Chickenpox Smallpox Mumps	Malaria Jaundice Any Liver Spleen or Gall bladder disease	Nephritis (Kidney or urine trouble) Diabetes etc. Prostate trouble

Malnutrition Rickets Rheumatism Backache	Any venereal disease like Syphillis Gonorrhoea etc.	Chronic Headaches, Numbness, Cramps, Fits, Convulsions Polio, Paralysis etc. Meningitis - Any Lumbar puncture done.	Miscarriage Abortion Currettings Sickness during Pregnancy etc. Prolapse of uterus
Diphtheria, Septic Tonsils, Adenoids Recurrent infections- Sinusitis Bronchitis- Eosinophilia Cold-Fever-Chill. Pneumonia Asthma- Pleurisy- T. B.	Any operation such as Tonsils, Abdomen, Appendix, Hernia, Piles Uterus, Renal stones, Gall stones, Phimosis, Hydrocele, Cataract etc. Mode of anaesthesia: general/local	Any heart trouble, Blood pressure, Giddiness	Any major accident Or injury to body or head. Any occasion of unconsciousness. Any major bleeding from any part of the body.
Any serious shock, grief, disappointments, fright, mental upset, depression or nervous breakdown.			Skin diseases like Pimples, Boils, Carbuncles, Ringworms, Fungus, Scabies, Eczema. Herpes, Urticaria, Allergy. Ulcers on any part of the body.

Diseases suffered from	@ Approx. Age	Whether you completely recovered ?	Duration (how long)	Any other particulars Medicines & treatment taken

Any extra remarks or information

Mention any drugs, tonics, stimulants etc. that have been used by you at any time in life

FAMILY INFORMATION

Here are List of Major Disease and table below this indicate the relationships with you in your family. Please provide the details about the diseases the relatives suffered and indicate they are alive / diseased. If they are diseased, then indicate the cause of death.

List of Major Disease

Anaemia Diabetes Paralysis Epilepsy / Fits	T. B. / Pleurisy Asthma	Bleeding tendency Cancer Leprosy
Rheumatism Hypertension Heart trouble	Kidney disease Liver disease etc. Eczema Urticaria	Insanity

Relationship	**Alive/dead**	**Years of life**	**Diseases suffered**	**Cause of Death**
Father				
Mother				
Paternal Grand Father				
Paternal Grand Mother				
Maternal Grand Father				
Maternal Grand Mother				

How many brothers - sisters are you? (including those who died, if any)
Provide information about them in the table below, Indicate your position by writing 'SELF'.

Brother / Sister elder to you younger to you…	**Alive/dead**	**age**	**Diseases suffered**	**Cause of Death**

Details of other relatives

Relationship	**Diseases suffered**
Paternal Uncle	
Paternal Aunts	
Maternal Uncle	
Maternal Aunts	
Cousin Brother & Sister on Father's Side	
Cousin Brother & Sister on Mother's Side	

Whom Do you resemble most?

Did any of your relatives have trouble like yours?

PERSONAL MEDICAL HISTORY

About your birth :
Did your mother have any problem during pregnancy?

Did she take any drugs during pregnancy? What were they?

Was there any difficulty about your birth? Give Details.

At what age did you start.

Growth Stages	Age	Any information regarding the stage
Teething		
Sitting		
Standing		
Walking		
Speaking		

Growth Functions	Age	Any information regarding the stage
Urine control / bed-wetting etc		
Eating indigestible like chalk, lime, earth, slate-pencil etc.		
Any other problem about your growth & development?		

Tick mark (✓) if any animal bites such as:

Dog	
Rat	
Snake	
Scorpion	
Any other	
Did you take anti-rabies or anti-venom or any other treatment?	

Vaccination & Innoculations:

Indicate number of times you were vaccinated for the following:

Smallpox		**Cholera**		**Typhoid**	
Polio		**Triple B. C. G**		**Tetanus**	
Measles		**Any other**			

Was there any reaction or trouble after any of above vaccination or innoculation?
Give details:

(If married) How is the health of your husband/wife :

Number of children living and dead. If dead, state causes.
Mention ages of children and their condition of health.

Child's Name	Male/Female	Age	Disease Suffered

Any abortions, miscarriages or still births?

Please mention about your habbits and intensity of the habbit.

Your Habits	How much?
Smoking	
Snuff	
Chewing tobacco	
Alcohol	
Tea	
Sleeping Pills	
Laxatives / Purgatives	
Any other	