

HEALING
— THE —
EYE
& Wellness Centers

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HOMEOPATHIC EVALUATION QUESTIONNAIRE

Dear Patient,

Please take your time and fill out this form. All this information is important and will be helpful in the selection of your homeopathic treatment. All your answers will be held in strict confidence.

Edward C. Kondrot, MD

TODAYS DATE

NAME

ADDRESS

CITY/ STATE/ ZIP

DAY & EVENING PHONE

E-MAIL

AGE

SEX

BIRTH DATE

PLACE OF BIRTH

PRESENT WT. & HT.

MARITAL STATUS

PROFESSION (OCCUPATION)

www.healingtheeye.com

1.800.430.9328

PRESENT COMPLAINTS. Please list each complaint and describe in detail (Use extra paper if necessary)

1.

2.

3.

4.

5.

ONSET ORIGIN OR CAUSE When did most of these complaints begin? Was there something which may have precipitated them, such as grief or shock?

PAST HISTORY (PREVIOUS DISEASES AND TREATMENT) List details about your past medical history, including operations and injuries.

MEDICATIONS List all of your medications that you are taking.

FAMILY HISTORY Give in detail if any of your relatives (note the relation to you) who are suffering or have suffered from the following :

ALLERGIES

Eczema Y___ N___
Skin allergy Y___ N___
Hay fever Y___ N___
Sinusitis or colds Y___ N___
Allergic bronchitis Y___ N___
Asthma Y___ N___
Urticaria Y___ N___

ARTHRITIS

Gout Y___ N___
Osteoarthritis Y___ N___
Rheumatoid arthritis Y___ N___

OTHER MEDICAL CONDITIONS

Cancer/Malignancy Y___ N___
Diabetes Mellitus Y___ N___
Hypertension Y___ N___
Coronary Heart Disease. Y___ N___
Tuberculosis (Pleurisy) Y___ N___
Gonorrhoea/Syphilis or STD Y___ N___
Psychiatric A Mental Disorders Y___ N___
Schizophrenia Y___ N___
Anxiety Neurosis Depression Y___ N___
Any other sickness not mentioned above.

PERSONAL HISTORY: Kindly elaborate and mention habits like alcohol, smoking, drugs tobacco etc.

APPETITE :

Grade as per preference +, ++ or +++/ dislike or aversion -1, -2 or -3

Sweets ___ What do you like?

Salt and salty food (any extra salt) ___

Sour things like pickles/ vinegar ___

Seasoned and spicy ___

Milk ___

Eggs ___

Fried foods and fat ___

Foods that you like ___

Foods that you dislike ___

Any complaints after eating? for example:

Fullness of abdomen Y ___ N ___

Gas formation Y ___ N ___

Diarrhea Y ___ N ___

Can you remain hungry for hours on end? Y ___ N ___

Does any item at food cause any discomfort e.g. acidity. headache, flatulence etc. Y ___ N ___

Do you feel bloated, full and heavy after eating Y ___ N ___

THIRST:

Say and grade +, ++ or +++

How much water do you take at one time and how many times per day.

Would you prefer cold/chilled water or drinks even in the height of winter?

Warm/ hot in the height of summer?

Iced cold drinks/ water ___

Cold drinks ___

Warm drinks ___

Very hot ___

GENERALITIES State how you are affected by or how you react to the following :

1. Cold in general: cold air, drafts, cold winds etc.
2. Warmth in general: warmth of bed or of room, external warmth etc.
3. Weather: dry, cold, wet weather, rains, cloudy etc.
4. Thunder storms?
5. Open fresh air?
6. Sunlight and exposure to the sun?
7. Near the sea? Near the mountains?
8. Eating and drinking (before, during or after) any symptoms?
9. Fasting?
10. Any particular item of food /drinks which adversely affect you (or make you sick) ?
11. Closed, crowded places (e.g.: elevators etc.)

12. Exertion or physical strain, mental strain ?

13. Lack of sleep ?

14. In what part of 24 hour day ...

Do you feel the best? Is there a specific time?

Do you feel the worst? Is there a specific time?

15. Do your troubles tend to occur or become worse periodically ? (e.g.; daily or alternate days, every week, yearly, during new or full moon etc.)

STOOL/BOWEL MOVEMENTS

- Do you regularly have a satisfactory bowel evacuations?
- How many times do you move the bowels? When?
- Consistency
- Odor
- Color of stool
- Any straining for stools, even though they might not be hard or constipated?
- Any urgency for stools (e.g. : do you have to run for bathroom first thing on waking up, in the morning or immediately after eating)
- Any pain, burning, bleeding with stools? Piles/Fissure/Fistula?
- Do you have flatus (wind) along with stools and is it noisy?

URINE

- Frequency, day and night; any smell (odor) in the urine?
- Any difficulty in passage of urine?
- Any difficulty in retaining urine?
- Any associated complaints with urination?

SEXUAL SPHERE FOR MEN

- Any sexual disturbance?
- Excessive desire or aversion to sex?
- Disability or performance, premature ejaculation etc.
- Night emissions
- Any H/O sexual abuse, excessive masturbation etc.?
- Any problem or complaints after intercourse?

FOR WOMEN

- Age of appearance of first period (Menarche)
- Pregnancies ___ Children ___ Abortions _____

MENSES

- Periods - Regular ___ or Irregular ___?
(heavy ___, scanty ___, clotted ___, color _____ odorous _____)
- Complaints associated with, before or after menses (e.g. headaches, irritability, premenstrual depression, diarrhea or constipation)
 - Any heaviness or pain in breasts before menses?
 - Any nodules in the breast, any other premenstrual symptoms?
 - Do you experience any sexual disturbances?
 - Desire/aversion to coitus?
 - Any leukorrhoeal (white discharge)? Itching, burning or discomfort?
 - Any sense of weight or bearing down at time of menses?

MENOPAUSE

- Age of _____
- Any associated complaints at time at menopause, e.g.: Hot flashes, palpitation, anxiety, depression etc.?

PERSPIRATION (SWEAT)

1. Do you perspire a lot?

2. Any particular part of the body, where you perspire more?
3. Any strong, offensive odor (e.g. sour etc.) associated with the sweat?
4. Does the perspiration stain the clothes?

SLEEP

1. Do you sleep well?
2. Any particular posture in which you sleep, lying on the sides, back or on your abdomen etc.?
3. Do you feel refreshed after sleep?
4. Do you dream while sleeping?
5. Any particular dream that is recalled and often repeated (e.g. : frightening dreams, falling from a height, being pursued by someone, or dead people etc.)
6. Do any of your complaints get worse or better before, during, or after sleep?

SKIN

1. Any skin problem that you have had earlier? (e.g.: allergies, eczema, fungal infections, pigmentation etc.)

2. Any itching or discoloration associated with it?

3. Any factors noticed which worsen the skin problem?

4. Any treatment taken for it?

5. Any complaint or abnormality of nails or the surrounding skin ?

6. Any complaint of hair falling out, early graying, dandruff, thinning, etc.?

7. Any warts, moles, birth marks on the body?

8. Does skin heal normally or takes very long to heal? Any tendency to form excessive scar tissue ? (Keloids)? Any tendency for wounds to suppurate (form pus easily)?

THE MIND

Have you noticed any marked changes in your mental state? If so describe in detail.

Have you become or are you

1 . Anxious/afraid of anything e.g.: being alone, animals, darkness, disease, thieves, robbers, sudden noises etc. ?

2. Suspicious, doubting ?

3. Impatient or hurried, hasty?

4. Offended easily (can't take any criticism) ?

5. Are you overly critical of others, always finding fault?

6. Irritable, quarrelsome, violent etc. ?

7. Depressed easily, sad or gloomy?

8. Timid/ shy, bashful ?

9. Jealous or suspicious?

10. Anxious, restless, nervous or excitable?

11. Do you feel very anxious and apprehensive before examination, before stressful situations, public engagements etc. ?

12. Are you silent, quiet, reserved or talkative? Make friends easily?

13. Are you very affectionate? Do you demand love and warmth from others?

14. Do you cry easily? What makes you cry (grief of others, music, kind words of affection etc.)

15. If someone consoles you when you are upset, does it help or does sympathizing with you makes matters worse?

16. Do you vent your worries, emotions etc., bottle them up inside you or brood over them?

17. How do you stand and react to contradiction?

18. Any imaginary fears or feelings? (e.g.: that someone might want to harm or hurt you or that people are against you)

19. How is your memory, power of concentration and mental ability?

20. Do you regret anything in life or resent certain people; if so who and for what reasons?

21. Do you feel humiliated or hurt easily? Would this give rise to any physical complaints?

22. Are you over conscientious about details., cleanliness, tidiness, punctuality, etc.?
Are you a perfectionist by nature, being meticulous, fastidious and even finicky?

23. What is the greatest grief that you have felt in life? Also what are the greatest joys in life you have experienced?

24. Can you mentally relax easily; for instance, can you switch your mind off work, problems, children, etc.? Do you enjoy vacations? And can you totally relax when on a holiday or do thoughts of work or what is happening at home keeps bothering you, etc.?

25. At work or with colleagues, subordinates, or your boss or seniors: How do you equate with them? Would reprimand or scolding from them upset you tremendously? If so how?

26. How does music affect you? What type of music do you listen to?