



Homeopathy Holistic Health Care

PALMA CICCO, HOM, DCHM (Hons)

Homeopathic Practitioner

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ADULT MEDICAL HISTORY FORM

Name: _____ Date of Birth: (D) ____/(M) ____/(Y) ____

Address: _____
Street City Postal code

Telephone: Home: _____ Work: _____ Mobile: _____

E-mail address: _____

Referred By: _____ Family Doctor & Phone no.: _____

Allergies: _____

Major Complaints in order of importance for you:

Complaint	Since	Causes

Which medications are you currently taking?

Medication	Since	Adverse Effects

What other treatments or regimes are you currently following?

Treatment or Regime	Since	Results

Please circle any of the following conditions you have had?

- | | | | | | | |
|--------------|---------------|----------------|-----------------|-----------------------------|----------------|---------------|
| Abscesses | Alcoholism | Allergies | Amnesia | Anemia | Arthritis | Asthma |
| Cancer | Chicken Pox | Cold Sores | Colitis | Depression | Diabetes | Emphysema |
| Epilepsy | Gall Stones | Goitre | Gonorrhoea | Gout | Hay Fever | Heart Disease |
| Hepatitis | Herpes | Influenza | Kidney Disease | Leukemia | Malaria | Measles |
| Miscarriage | Mononucleosis | Mumps | Parasites | Pelvic Inflammatory Disease | PCOS | PCOS |
| Pleurisy | Pneumonia | Prostatitis | Rheumatic Fever | Rubella | Scarlet Fever | Sexual Abuse |
| Skin Disease | Strep Throat | Sinusitis | Stroke | Sun Stroke | Thyroid issues | Tonsillitis |
| Tuberculosis | Warts | Whooping Cough | Worms | Yellow Fever | | |

Any other major conditions? _____
 Are there any of the preceding conditions after which you have not been totally well again?
 Which Ones? _____

(Women) Age of first menstrual cycle: _____ (Women) Number of Pregnancies: _____

Are you currently under the care of a physician(s)? Y / N

Physician Name	For Which Condition?	Treatments
_____	_____	_____
_____	_____	_____

What major operations have you had?

Operation	When	Complications

What major injuries have you had?

Injury	When	Complications

How much of the following substances are you using?

Tobacco _____ Alcohol _____ Coffee _____ Recreational Drugs _____

Indicate below, which of the following ailments, or any other major ailments, have affected your relatives:

- | | | | | | | |
|--------------|-----------|--------------|---------------|----------|------------|-----------|
| Alcoholism | Allergies | Arthritis | Asthma | Cancer | Depression | Diabetes |
| Epilepsy | Gonorrhea | Gout | Heart Disease | Insanity | Paralysis | Pneumonia |
| Skin Disease | Syphilis | Tuberculosis | | | | |

Relative	Age if alive	Age at death	Ailments
Mother			
Father			
Brothers/Sisters			
Son/Daughter			
Grandmother/Grandfather			

Is there any other information that I would need to know? _____

Medical/Professional Waiver

PLEASE READ THE FOLLOWING CAREFULLY (if under 19 years of age, a parent or guardian must sign). I, the undersigned, understand that *Palma Cicco* is a homeopathic practitioner of classical homeopathy and not a licensed medical doctor. As such, I acknowledge that it is my responsibility to seek medical diagnosis and advice for my present and future conditions. In consulting with *Palma Cicco*, I am exercising my right to choose an alternative method of treatment through which to address my total health. As homeopathy is not covered by the existing government medical insurance plan, I agree to pay all fees presented in the current rate schedule. I agree that "symptoms" from my consultations may be used for homeopathic teaching purposes. I acknowledge that all personal information will be kept confidential. I consent that from time to time I may receive e-mails/texts from *Palma Cicco* and/or any of her other business locations, which will provide me with confirmation of appointments, relevant health information, newsletters, upcoming events, homeopathic and natural health seminars and learning opportunities. I understand that I can unsubscribe to these e-mails/texts at any time.

Patient Signature: _____ **Date:** _____