JOHNSON MEDICAL ASSOCIATES

HOW TO REPORT SYMPTOMS

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1. Always describe:
   - ✓The beginning of your complaints, (or of patients who are young, or need help)
   - ✓State just how they began as well the changes that may have taken place since.

2. Mention all previous illnesses and give a complete history of your health i.e.:
   - ✓Skin diseases
   - ✓Children's diseases
   - ✓After-effects of illness
   - ✓Fevers, colds, flus, sores, ulcers
   - ✓Severe Injuries: Their location and type
   - ✓What treatment was used?

3. Mention all medical treatments that have been used in the past.
   - ✓Note the year or your age if you can.

4. Describe all mental or "nervous" feelings and conditions, such as:

Likes	Dislikes	Discontent	Absentminded
Desires	Fears	Overly conscientious	Hard to concentrate
Critical	Hurried Feeling	Irritable	Mental dullness
Confused	Lack of interest	Timidity	
Discouraged	Persistent thoughts	Moody	

a. Are You Startled By:

Noise?	Being touched?	From sleep?	When falling asleep?

b. Do you like or dislike business or work?
c. Feel better from mental work?
d. Feel better from physical exertion?
e. Is noise, the talk of others annoying?
f. Is the crying of children annoying?
g. Are you easily affected by bad news?
h. Sensitive to offense or contradiction?
i. How do you feel about the future?
j. How affected by friends & relatives?
k. Prefer company or feel better alone?
l. Like or dislike a room full of people?
m. Any recent or past emotional shocks, frights, or disappointments?

5. Describe your appetite.
   ✓Small, large or changeable?
   ✓Food & drinks you prefer, and make you feel better or worse afterward.
   ✓Include salt, sweets, fats, sour, spicy, eggs, meat, vegetables etc.
   ✓Drink a lot, a little, or not thirsty?
   ✓Foods & drinks you dislike?
   ✓Hot, cold, or warm food or drink?

6. Do your symptoms remain the same?
   ✓Change character or shift around?

7. Pain Descriptions: *

How it feels.	Ache or pressure?	Is it constant?	Does it change?
Is it come and go?	Does it wander?	Go up or down?	Go out or across?
Go right to left?	Go left to right?	Slow/quick to heal	Quick/slow onset

8. What Makes You Better or Worse?

Day or night?	Sleep?	Seasons?	Motion?	Rest?	Month?

9. How Do Weather Types Affect You?

Cold & dry	Cold & humid	Rainy	Frosty/Foggy	Low Altitude	Cloudy
Hot & dry	Hot & humid	Snowy	Thunderstorm	High Altitude	At the seashore

10. Sensations are important. Note:

Kind	Where	Time

✓What makes it better or worse?

✓Tell all sensations however slight or
✓Peculiar e.g.: it feels "as if".

11. Describe skin, scalp, or nail problems:

Location	Color	Dry	Scaly	Thick	Burn	Discharge
Growths	Warts	Moist	Pimply	Thin	Itch	Crippled

✓Is it better or worse by scratching?
✓Does heat, warm bed/room, cold, wool, exercise, or warm or cool water help?
✓Have varicose, spider or large veins?

12. Describe discharges of any part, as to:

Small amount	Large amount	Color	Raw	Gluey/sticky	Redness
Odor	Time of day	Thin	Thick	Burning	Stained

✓What Makes It Better Or Worse?

13. Describe Urinary Symptoms of:

Frequency	Sudden urge	Pain: after	Pain: during	Pain: before
Urine sediment	Kidney pain	Urine color	Urethra pain	Bladder pain
Lose urine	Slow stream	Prostatitis	Sugar in urine	

14. Describe Bowel Symptoms:

Rectal spasms	No urge for BM	Stool recedes	Diarrhea
Hemorrhoids	Incomplete stools	Difficult stool	Urge w/o results

Stool Description:

Color	Odor	Hard	Narrow	Bloody	Slimy	Watery	Pappy
Dry	Large	Small	Pasty	Frothy	Thin	Flat	

✓Note anything unusual.

15. Female Symptoms:

Age menses began	Regular cycle	To side, groin/thigh	Painful?
Pain location & type	Irregular cycle	Pain goes to Back?	Clotted?

Describe the type of pain (See No. 7*):

- ✓What helps or makes the pain worse.
- ✓Childbearing history: miscarriages, live births, C-sections, etc.
- ✓How do you feel in general before, during and after your period?
- ✓Is there sexual desire or aversion?
- ✓Is intercourse normal, or painful?
- ✓Is there a vaginal discharge, itching, burning or eruptions?

16. Male Symptoms: Note any Abnormality of Male Organs.

- ✓Is there any pain, itching, burning, perspiration, or skin eruptions?
- ✓Is intercourse satisfactory etc.?
- ✓Are there nightly emissions?
- ✓Is sexual desire/performance normal?

17. How Do You Feel from the Effects of:

- ✓Hot, warm or cold temperatures, and from hot/warm/cold bathing?
- ✓Does moving or lying down feel better?
- ✓Are you better or worse when you perspire?
- ✓Are you tired, weak or weary?
- ✓How does exercise affect you?

18. **Similia Similibus Currentur:**
(Let Likes Be Cured By Likes)

Implies Strict Individualization.

- ✓In other words, the curative remedy is the one that has produced in healthy human beings symptoms most similar to those, which distinguish the patient from all others suffering from the same ailment.
- ✓They are the more striking, singular, uncommon, and peculiar symptoms—because they are more notable and remarkable; singular because they are unique, strange, unusual and therefore distinctive.
- ✓These symptoms are *characteristic and peculiar* because they belong to the individual, and to the remedy that cures.
- ✓They are uncommon because as they are seldom found in other individuals or in the pathogenesis of other remedies.

JOHNSON MEDICAL ASSOCIATES

MEDICAL HISTORY QUESTIONNAIRE FOR HOMEOPATHY PATIENTS

Judith J. Pruzzo R.Ph., C.C.H.

Please fill in blanks as completely as possible.

Name: _____ Age _____ Phone _____

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

If you ever had any of the following, check yes. Note year or age in "When" column

ILLNESSES:	Yes	When?	ILLNESSES:	Yes	When?	MEDICATIONS	Now	When?
A.I.D.S.			Ovarian Cyst			Allergy shots		
Abnormal urinalysis			Parkinson's disease			Anabolic steroids		
Anemia			Persistent hoarseness			Antibiotics		
Appendicitis			Pleurisy			Anti-Candida		
Arthritis			Pneumonia			Anti-coagulants		
Asthma			Poison Ivy			Anti-depressants		
Birth defect (explain)			Prostate infection			Anti-Fungal		
Bladder infections			Psoriasis			Antihistamines		
Blood Disorder			Recurrent chest pain			Anti-malarial		
Bone disease			Recurrent headaches			Anti-thyroid		
Breast tumor or cyst			Rheumatic fever			Anti-tubercular		
Bronchitis			Rheumatism			Aspirin		
Cancer (specify)			Scarlet fever			Birth Control Pill		
Cataracts			Sexual dysfunction			Blood thinner		
Colitis or irritable bowel			Shortness of breath			Chemotherapy		
Convulsions or epilepsy			Sinus headaches			Cortisone		
Diabetes ☐ ype I ☐ pe II			Sinusitis: acute or chronic			Cough medicine		
Duodenal ulcer			Sore or strep throat			Digitalis		
Ear infections			Stomach ulcer			Diuretic "water pill"		
Eczema			Stroke			Estrogen		
Electro-Magnetic Sensitivity: EMF			Sudden weight gain			Herbal medicines		
Electroshock therapy			Thyroid disorder			Homeopathic meds		
Emphysema/Lung disease			Tonsillitis			Ibuprofen: Advil		
Encephalitis/sleeping sickness			Tuberculosis			Iron supplement		
Endometriosis			Unexplained weight loss			Laxative		
Fainting spells			Venereal Disease:			Narcotic pain relief		
Gall bladder disorder			Chlamydia			Nitroglycerin		
Glaucoma			Genital herpes			Pep pills "uppers"		
Gout			Gonorrhea			Prednisone		
Head or spinal injury			Syphilis			Progesterone		
Heart disease			**Other past or present illness**:		**When?**	Quinine		
Heartburn/acid reflux						Ritalin		
Hemorrhoids						Sleeping pills		
Hepatitis A, B, or C						Sulfa drugs		
High Blood Pressure						Testosterone		
Infection of female organs			**All Rx & OTC Meds/Vit/Min/Herbs**			Thyroid		
Jaundice			**1**			Tranquilizers		
Kidney or bladder disease			**2**			Tylenol: acetaminophen		
Kidney stones			**3**			Vitamins and minerals		
Long confinement from illness			**4**			Wt control "diet pill"		
Malaria			**5**			**Other Past Medications**		
Meningitis			**6**			**1**		
Migraine or severe headache			**7**			**2**		
Mononucleosis			**8**			**3**		
Multiple Chemical Sensitivity: MCI			**9**			**4**		
Multiple sclerosis			**10**			**5**		
Neck or back pain			**11**			**6**		
Nervous breakdown			**12**			**7**		

MEDICAL HISTORY QUESTIONNAIRE FOR HOMEOPATHY PATIENTS

ALLERGIES:			SURGERIES			VACCINATIONS or DISEASE		
If check yes, note date/age	Yes	When?	If check yes, note date/age	Yes	When?	Please check one	Vacc	Disease
Aspirin	☐		Adenoids	☐		Chicken Pox	☐	☐
Asthma Meds	☐		Appendectomy	☐		Diphtheria	☐	☐
Codeine	☐		Breast tumor or cyst	☐		Influenza	☐	☐
Darvon	☐		Ear surgery	☐		Hemophilis influenza B	☐	☐
Demerol	☐		Extremities	☐		Hepatitis: ☐ A ☐ B	☐	☐
DPT or MMR vaccine	☐		Eye surgery	☐		Measles: 3-day	☐	☐
Erythromycin	☐		Gall bladder	☐		Measles: 7-day	☐	☐
Food Allergies	☐		Heart surgery	☐		Measles: infantile	☐	☐
Morphine	☐		Hemorrhoids	☐		Mumps	☐	☐
Novocain	☐		Hernia: umbilical or inguinal	☐		Pertussis:whoop cough	☐	☐
Penicillin	☐		Hysterectomy	☐		Pneumonia	☐	☐
Sedatives	☐		Kidney or bladder	☐		Small Pox	☐	☐
Sleeping pills	☐		Mastectomy	☐		Typhoid fever	☐	☐
Sulfa Drugs	☐		Nose surgery	☐		Typhus fever	☐	☐
Tetanus shot	☐		Ovarian cyst(s)	☐		Yellow fever	☐	☐
Tetracycline	☐		Prostate	☐		Other:	☐	☐
Tree or Grass Allergies	☐		Stomach	☐			☐	☐
Xylocaine	☐		Thyroid	☐		**HAVE YOU EVER HAD ?**		
Specify other allergies below:		**When?**	Tonsillectomy	☐			**Yes**	**When?**
			Varicose veins	☐		Blood test for STD	☐	
			Wisdom teeth extracted:	☐		Blood transfusion(s)	☐	
			List other surgeries below:		**When?**	EKG:	☐	
						Stress Test	☐	
						Blood Type: ☐ A ☐ AB ☐ B		
						☐ O ☐ Positive ☐ Negative		
X-RAYS and SCANS	**Yes**	**When?**	**Injury/Accident/Fracture**	**Yes**	**When?**	**Present problems or symptoms:**		
Back/spine	☐		Broken or cracked bone(s):	☐		**1**		
Brain scan	☐		**Explain:**			**2**		
CAT scan	☐					**3**		
Chest	☐		Concussion	☐		**4**		
Colon: "Lower G.I."	☐		Dislocations	☐		**5**		
Dental X-rays	☐		Electrical shock "severe"	☐		**6**		
Estimate # of Lifetime X-rays:	☐		Head injury	☐		**7**		
Extremities	☐		Knocked unconscious	☐		**8**		
Fluoroscopes to fit shoes	☐		Laceration "severe cut"	☐		**9**		
Gall bladder	☐		Sunburn: "severe"	☐		**10**		
Kidney/ureters/bladder	☐		**Explain:**			**11**		
Liver Scan	☐					**12**		
M.R.I.	☐		**Current & Past Habits**		**When?**	**Date symptoms began:**		
Mammogram	☐		Alcohol	☐		**Purpose of visit:**		
Radiation treatments	☐		Tobacco	☐				
Sonogram	☐		Recreational drugs:	☐				
Stomach: "Upper G.I."	☐		Cannabis "Pot"	☐		**Other pertinent information:**		
Thyroid scan	☐		Cocaine	☐				
List other X-rays and date below:			Ecstasy	☐				
			LSD	☐				
			Methamphetamine	☐				
			Nutrition: ☐ Fair ☐ Good					
			☐ Healthy ☐ Junk food					

MEDICAL HISTORY QUESTIONNAIRE FOR HOMEOPATHY PATIENTS

Please check any of the following that you currently have, or have had in the past year or two.

☐ Change in the size, shape, color or texture of bowel movements ☐ Hard stool ☐ Constipation ☐ Diarrhea

Urination: ☐ Difficult to start ☐ Painful ☐ Frequent: ☐ Daytime ☐ Night Blood in: ☐ Urine ☐ Stool

Loss of urine: ☐ Cough ☐ Sneeze ☐ Laugh ☐ During sleep ☐ If delay going

Joints: ☐ Persistent pain ☐ Stiffness ☐ Swelling Muscle: ☐ Spasms ☐ Cramps Where?

☐ Lips ☐ Fingers or ☐ Toes turn blue, purple or white from the cold ☐ Night sweats ☐ Hot flashes

☐ Tired, fatigued or weak without apparent reason ☐ Fainting ☐ Faintness ☐ Dizzy ☐ Light-headed

☐ Bruise easily Discharge from: ☐ Eyes ☐ Ears ☐ Nose ☐ Urethra ☐ Vagina ☐ Rectum

☐ Recurrent nosebleeds ☐ Difficulty swallowing: ☐ Pills ☐ Food ☐ Drink

☐ Enlarged or swollen glands Where?

☐ Short of breath: ☐ Climbing stairs ☐ During sleep ☐ Lying flat

☐ Chronic cough ☐ Cough up blood ☐ Chest pain ☐ Sores or eruption on sexual organs

WOMEN ONLY

Menstrual periods: ☐ Are or ☐ Used to be ☐ Irregular ☐ Regular ☐ Late ☐ Normal ☐ Heavy ☐ Too long

☐ Clots: ☐ Dark ☐ Red ☐ Stop 1-2 days & restart ☐ Brown: ☐ At start ☐ At end

Lasts for: ☐ 2-3 days ☐ 4-6 days ☐ 7-10 days ☐ Spotting: ☐ At ovulation ☐ At start ☐ At end

If painful, describe the type of pain and whether it is in the ovaries, uterus, or abdomen and if it goes to back or legs.

Date of last period: _____ Age periods began: _____ Age periods quit: _____ Date of last Pap smear: _____

Results: ☐ Negative ☐ Positive ☐ Vaginal itching ☐ Vaginal discharge ☐ White ☐ Green ☐ Yellow

☐ Intercourse painful ☐ Vaginal dryness ☐ Use estrogen cream ☐ Need lubricants

Please fill in the number in blanks provided and check those applicable in line below:

Pregnancy: _____ Live birth: _____ Stillbirth: _____ Miscarriage: _____ Abortion: _____ Cesarean : _____

☐ Twins ☐ Triplets ☐ Back labor ☐ Breech birth ☐ Complications from Rh factor

Please give additional information on any difficulties during pregnancy or delivery, as well as menstrual problems or changes that occurred after menopause, childbirth, pregnancy or hormonal medications.

ADDITIONAL INFORMATION FOR CONSULTATION

MEDICAL HISTORY QUESTIONNAIRE FOR HOMEOPATHY PATIENTS

Please check any of the following symptoms or conditions that apply:

BOWELS and STOOL	DISCHARGE FROM:	COLOR CHANGE WHEN COLD:
constipated ☐	ears ☐	hands/fingers ☐
diarrhea ☐	eyes ☐	feet/toes: ☐
hard stool ☐	nose ☐	blue ☐
irritable bowel ☐	rectum ☐	purple ☐
soft stool ☐	urethra ☐	white ☐
URINATION	**DISCHARGE TYPE**	**PERSPIRATION:**
frequent: day ☐	clear ☐	none ☐
frequent: night ☐	green ☐	scanty ☐
slow to start ☐	offensive ☐	moderate ☐
lose urine ☐	thick ☐	heavy ☐
JOINTS	thin ☐	offensive ☐
painful ☐	watery ☐	**DIFFICULT BREATHING:**
stiff ☐	white ☐	climb stairs ☐
swollen ☐	yellow ☐	sleep apnea ☐
MUSCLES	**DIFFICULT SWALLOWING:**	**CHRONIC COUGH**
cramp ☐	dry food ☐	cough up blood ☐
sore ☐	dry cheese ☐	cough up mucus ☐
stiff ☐	liquids ☐	must swallow mucus ☐
tight ☐	pills ☐	sleep with head high ☐
WOMEN ONLY		
MENSTRUAL PERIODS	**SPOTTING:**	**MENSTRUAL FLOW**
Now or in the past: irregular ☐	brown ☐	brown ☐
late ☐	red ☐	heavy ☐
painful ☐	at start of period ☐	red ☐
regular ☐	at mid-cycle ☐	very light ☐
short ☐	at end of period ☐	stop 1 day & resume ☐
last period began:	**CLOTTING**	**LENGTH OF PERIODS**
age periods began:	dark red ☐	2-3 days ☐
age periods quit:	black ☐	4-7 days ☐
last pap smear:	very large ☐	over 8 days ☐
FIBROID TUMORS	**MENOPAUSE**	**OVARIES:**
ovaries ☐	post-menopausal ☐	1 ovary removed ☐
uterus ☐	peri-menopausal ☐	2 ovaries removed ☐
PREGNANCY and BIRTH	**LABOR AND DELIVERY**	**CONCEPTION**
Note number of: abortions	back labor ☐	blocked fallopian tubes ☐
ectopic	breech ☐	hormone treatment ☐
live birth	caesarean ☐	in vitro fertilization ☐
miscarriage	Rh factor ☐	unable to conceive ☐
pregnancy	triplets ☐	other:
still birth	twins ☐	

Please relate pertinent information about any of above topics in space provided below.

Tel: 972-479-0400 ● 997 Hampshire Lane ● Richardson TX 75080 ● Fax: 972-479-9435

FAMILY and HEALTH HISTORY

Please put and X in the rows across, if condition has ever applied to blood relative listed in family column (on far left).
If you are adopted, with no knowledge of birth parents check here. ☐

Family Names of close living and deceased relatives	Brother	Sister	Health Status G = Good F = Fair P= Poor	Birth Year	COMMON DISEASES AND DISORDERS Alcoholic/heavy drinker	Allergies/asthma/sinus	Anemia/hemophilia	Arthritis/rheumatism	Lung/emphysema	Cancer/tumor	Diabetes/glands/thyroid	Stomach/colon	Heart/circulation	Hypertension/stroke	Kidney/bladder	Psychiatric disorder	Migraines	Died from	Age now or when died
Yourself																			
Mother																			
Father																			
Maternal grandmother																			
Maternal grandfather																			
Paternal grandmother																			
Paternal grandfather																			

Check family diseases and list only blood relative affected in space provided, using abbreviations below*

☐ alcoholism	☐ cancer	☐ encephalitis	☐ gonorrhea	☐ malaria
☐ Parkinson's	☐ polio	☐ syphilis	☐ tuberculosis	☐ other:

Abbreviations: P: paternal M: maternal G: grand F: father M: mother A: aunt U: uncle GG:great grand i.e.: PGF: paternal grandfather

PRENATAL and BIRTH HISTORY: **Check any that occured when mother was pregnant with you.**

☐ alcoholism ☐ hypertension ☐ albumin in urine ☐ kidney infection ☐ German measles ☐ high-risk pregnancy
☐ tobacco use If so, how many packs a day? ☐ chlamydia ☐ gonorrhea ☐ syphilis ☐ Alcohol daily ☐ Meds: ☐ Rx ☐ OTC
☐ crack/cocaine ☐ marijuana ☐ street drugs ☐ uppers ☐ downers ☐ other ☐ antibiotics ☐ aspirin ☐ hormones
☐ cord around neck ☐ eclampsia ☐ toxemia ☐ premature ☐ C-Section ☐ breech ☐ posterior ☐ face-up ☐ forceps ☐ fetal distress
☐ multiple birth # babies ☐ Difficult delivery Birth weight: lbs. oz ☐ Rh problem ☐ blood exchange ☐ resuscitated @ birth
☐ vacuum/suction ☐ other birth difficulties: # Sonograms: ☐ near miscarriage
☐ incubator for: ☐ weeks or ☐ months # children mother delivered before you? # siblings who died at or shortly after birth?
If patient is a child or is disabled, who is main caregiver? How many children live with you?

JOHNSON MEDICAL ASSOCIATES

HOMEOPATHIC INTERVIEW QUESTIONS

Please put a ☑ or X in the checkbox, if applies or a brief answer space provided.

With difficulties, do you	☐ Finish or	☐ Quit	☐ High school		☐ College	☐ Projects?	☐ Act	☐ Postpone
Desire to have children is, or was		☐ High	☐ Medium	☐ Low	☐ None	☐ Worn out from child-rearing		
Have strong to medium desire for:		☐ Bacon	☐ Ham	☐ Sugar	☐ Coffee	☐ Chocolate	☐ Sausage	
☐ Water	☐ Dill or sour pickles	☐ Vinegar	☐ Salt	☐ Veggies	☐ Juice	☐ Ice	☐ Green fruit	
List foods/beverages you dislike:								
☐ Worry about opinion of others		☐ Want to be liked by everyone			☐ Feel unappreciated			
Childhood:	☐ Tomboy ☐ Dolls	☐ Team sports	☐ Gymnastics		☐ Dance	☐ Soccer	☐ Music	☐ Karate
Learning:	☐ Love ☐ Hate	☐ Possibly slow to learn things			☐ Directions difficult unless repeated			
Type of work preferred:	☐ Mental	☐ Manual	☐ With people		☐ Work alone		☐ Outside	☐ Inside
Affection:	☐ Desire ☐ No need	☐ Dislike	☐ Return affection		☐ Friendly		☐ Silent	☐ Loner
Are you particular about order at:		☐ Home	☐ Office	☐ Work	☐ Auto	☐ Truck	☐ Kitchen	☐ Bathroom
☐ Looks in public	☐ Clothes	☐ Hair	☐ Take care of things		☐ Collect things		☐ Neat	☐ Messy
Bothered by:	☐ Disorderly house	☐ Crooked picture		☐ Cabinet door open		☐ Dirt	☐ Germs	☐ Clutter
Money:	☐ Spend ☐ Save	☐ Frugal	☐ Gamble	☐ Generous	☐ Worry	☐ Lottery	☐ Try to impress others	
Sensitive to:	☐ Cold air ☐ Fan	☐ Draft of air	☐ Heat of sun		☐ Cold wind		☐ Winter	☐ Need hat
☐ Chilly from uncovered hand, leg or foot in cold room				☐ Sleepless if hands or feet are cold				
☐ Fascinated by fireworks, matches or fire		☐ As a child	☐ Now					
☐ Desire peace and harmony		☐ Dislike quarreling						
☐ Witnessed a bad accident		☐ Almost in a bad-accident			☐ Thought was about to die			
Give details:								
Fears:	☐ Alone ☐ Animals	☐ Cockroach or bugs		☐ Cancer	☐ Crowds	☐ Dark	☐ Heights	☐ Insects
☐ Narrow place	☐ Robber	☐ Snake	☐ Spider	☐ Strange	☐ Suffocation		☐ Water	
Vacation:	☐ Shop ☐ Hike	☐ Fish	☐ Beach	☐ Home	☐ Travel	☐ TV	☐ Cinema	☐ Theatre
Exercise:	☐ Often ☐ Some	☐ Dance	☐ Run	Sports:	☐ Watch	☐ Play	☐ Team	☐ Individual
Housework:	☐ Hate ☐ Like	Cooking:	☐ Love	☐ Hate	☐ Never have time		☐ Dine out	
Relationships:	☐ Long-lasting	☐ Short	☐ Painful	Have you ever?	☐ Fainted		☐ Had a seizure	
☐ Became unconscious	For a:	☐ Short time	☐ Long time	Due to:	☐ Injury		☐ High fever	
Give details:								
Comments:								