PATIENT DETAILS

Name ………………………………………………….………………………………

Date of Birth …………………………………………………………………………

Address ……………………………………………….………………………………

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………………………………………………………….……………………………..

Telephone ….......……………………………………………………………………..

Mobile ………………………………………………….……………………………..

Email address………………………………………………………………………….

Name of GP ………………………………………….……………………………….

Address of GP ………………………………………………………………………..

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Name of Specialist Practitioner ………………………………………………………

Address ……………………………………………….………………………………

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MEDICATION AND TREATMENT TO DATE

Please list all current medication, vitamins and supplements you are taking…………

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Please mention any other therapies you have used, and the ailments they were used for ………………………………………………………………………………………

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Please list vaccinations and any reactions to them …………………………………….

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Do you have any allergies or intolerances ?……………………………………….

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Please state any recreational drugs you have used or are currently using ………….

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Please list all illnesses, diseases, accidents, operations (including cosmetic), hospitalisations and medical tests you have had, and if possible the year or your age when you had them. …….… ……………………………………………………………………...………..

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Please list any long-term prescriptions you have taken, and when you were on them e.g. the pill, HRT, blood pressure tablets, hay-fever medication, pain relief products etc. ……………………...……...………………………………………………………………

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Please list the childhood illnesses you had and if possible, the year or your age at the time …………………………………………………………………………………….

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Have you experienced any life traumas e.g. bereavement, divorce, moving etc? What year was this or what age were you? ………………………………………………………………………….………….

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FAMILY MEDICAL HISTORY

Please state the illnesses your relatives suffer from or died from.

Paternal Grandmother …………………………………………………………………..

Paternal Grandfather ……………………………………………………………………

Maternal Grandmother …………………………………………………………………

Maternal Grandfather …………………………………………………………………..

Mother ………………………………………………………………………………….

Father …………………………………………………………………………………..

Aunts ..………………………………………………………………………………….

Uncles ………………………………………………………………………………….

Siblings ………………………………………………………………………………….

Has anyone in your family had the following? Please state which relative and their approximate age where appropriate:

Alcoholism……………………………………………………………………………...

Drug use/abuse………………………………………………………………………….

Please state which drug/s ………………………………………………………………

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Down’s Syndrome………………………………………………………………………

Epilepsy ………………………………………………………………………………...

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Behavioural problems ………………………………………………………………….

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Diabetes …………………………………………………………………………………

Cancer …………………………………………………………………………………..

Depression ……………………………………………………………………………….

Stroke ……………………………………………………………………………………..

Suicide / attempted suicide ……………………………………………………………….

Anxiety ……………………………………………………………………………………

Heart attack ………………………………………………………………………………..

High blood pressure ………………………………………………………………………..

Asthma ……………………………………………………………………………………..

Hay-fever……………………………………………………………………………………

Eczema / psoriasis …………………………………………………………………………

Glandular Fever…………………………………………………………………………….

Sexually transmitted disease ……………………….…..…………………………………..

Rheumatoid Arthritis …………………………………..……………………………………

Tuberculosis ……………………………………………………………………………….. Adoption / abandonment ……………………………………………………………………

DATA PROTECTION

By signing this document you give Alison Endenburg permission to use the information provided to:

1. analyse the conditions for which you have consulted me and prescribe remedies and other therapies
2. communicate with you about your appointments and symptoms by email, landline, mobile phone
3. use your postal address to send remedies to you if necessary

Your information will not be shared with any third parties without your prior consent.

You can at any time request that your personal information not be used for these purposes by contacting [alison.endenburg@gmail.com](mailto:alison.endenburg@gmail.com) or writing to Alison Endenburg, Hebu Clinic, 47 High Street, Tonbridge, TN9 1SD.

**Cancellation policy**

Kindly phone or email me within 24 hours of your appointment if you want to cancel it. If you don’t cancel within this notice period you will be charged the cancellation fee of £30 which will have to be paid before your next appointment. Thank you.

Consent: I hereby confirm that I have requested Homeopathic treatment from Alison Endenburg and have read an understood the data protection and cancellation policies above.

Signed ………………………………

Dated ……………………………….