DR SUMAN MOHAN’S CLINICS

**DR. SUMAN MOHAN**

BHMS, PG Diploma in Preventive and Promotive Health

Care (PGD PPHC), MSc – Dietitics/ Nutrition, Certificate

In Yoga & Meditation, Certificate Course in Child Psychology,

Homeopath, Dietitian/ Nutritionist, 10 years

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### CASE RECORD PROFORMA

CASE REFERENCE NO. DATE



DIAGNOSIS



NAME SURNAME



## FATHER’S / MOTHER’S NAME

AGE SEX PRESENT WT. & HT.



## NATIONALITY MARITAL STATUS

PROFESSION / OCCUPATION:



ADDRESS



TELEPHONE’S



FAX NO.



EMAIL ADDRESS



**(for patients who record their own complaints e.g. postal cases)**

GENERAL DIRECTIONS FOR HOMOEOPATHIC TREATMENT

Before filling in this questionnaire/case history proforma, the following directions should be kept in mind . In order to get the maximum benefit from our consultations we need to know ALL POSSIBLE DETAILS ABOUT YOUR AILMENTS. When answering the questions give maximum possible information especially in your own words, describing-

(i) particularly any peculiarities your might have noticed about yourself;

(ii) try avoiding medical terminology as far as possible and be as narrative as if describing complaints to a friend.

Numerous questions are posted before you covering the totality of your symptoms. In order to make a thorough and complete prescription, you will have to take pains to glance through all of them. Since HOMOEOPATHY TRIES TO TREAT THE TOTALITY OF THE SICKNESS i.e. the patient as a whole and not one or the other disease, the fuller the report, the better is the selection of the curative remedy.

**IMPORTANT**

**In describing the complaints, try to give the specific location and sensation of complaints; how they appear or disappear and factors or conditions which increase or relieve the complaints. Any specific time that these are better or worse may also be mentioned.**

If you have any complaints of PAIN --- describe the sensation or pain in your own language --- just as it feels to you.

e.g.: types of pain - cutting, boring, digging, soreness, aching, burning, cramp like, shooting, pressing, pricking, stitching, wandering etc.

Does the pain remain in one place or change place?

Describe, where the pain begins and where it extends to?

HOW ARE YOUR COMPLAINTS OR PROBLEMS, BETTER OR HOW DO THEY BECOME WORSE? say Headache etc.

Is there any act or position, any part of the day or night, application of cold and warm water, or dry heat or cold, any changes with weather, cold or warm air or any other circumstances (Including emotional factors) that cause pain to be eased or worsen it or remove it entirely?

Does pain etc. comes suddenly and goes suddenly? or appears gradually? or disappears gradually etc?

**PRESENT COMPLAINTS**

MAIN COMPLAINTS (Detailed history of the present illness, the onset and course

with dates and conditions of aggravation and relief)

1

2

3

4

5

6

**ONSET**

Origin or cause - Can you trace the origin of the present illness to any

particular circumstance like accident, illness or infection,

mental or emotional shock or use of drugs etc.

**PAST HISTORY (PREVIOUS DISEASES AND TREATMENT)** - in chronological order or arrangement if possible

**FAMILY HISTORY:**

Give in detail if any of your relatives (say Parents, Grandparents, Uncle & Aunty) are suffering or have suffered from the following.

List of diseases: (Blood relations affected)

**I Allergies:**

Eczema, skin allergy

Hay fever

Sinusitis, Colds

Allergic bronchitis

Asthma

Urticaria

II **Arthritis:**

Gout

Osteo-arthritis

Rheumatoid arthritis

**III. Cancer/Malignancy**

**IV. Diabetes Mellitus**

**V. Hypertension**

**VI. Heart trouble:**

Ischaemic Heart Disease, Angina etc.

**VII. Tuberculosis (Pleurisy)**

**VIII Gonorrhoea / Syphilis or STD**

**IX. Psychiatric & Mental Disorders**

**X. Schizophrenia**

**XI. Anxiety Neurosis / Depression**

**XII. Any other sickness not mentioned above?**

**PERSONAL HISTORY**

Kindly elaborate and mention habits, addictions like alcohol, smoking, drugs, tobacco etc

**Appetite:** What particular foods or drinks do you strongly **crave for** or desire and what are you strongly averse to or dislike say **Yes/No.** and state your preference as +, ++, +++ etc depending on strong likes & dislikes or aversion.

Least Craving/Liking +, More Liking/Craving ++, Most Craving/Liking+++

Do you dislike specific food eg. sweets , salty etc

Sweets

Salty food

Do you add Extra salt in your food?

Sour things / pickles

Seasoned and spicy

Milk

Eggs

Fried and fats

Any other cravings in food?

.

**How is your Digestion?**

Any complaints after eating for example-

Fullness of abdomen, Gas formation or Diarrhoea Yes/No

Can you remain hungry for hours on end without?

1. Does any item of food cause any discomfort e.g. acidity, headache, flatulence etc. Yes/No

2. Do you feel bloated, full and heavy after eating Yes/No



**Thirst :**

How is your thirst? Please mention the grade of thirst? If you are very thirsty, you may mention grades +, ++ or +++

How much water do you take at a time?

How many times per day?

Your preference in drinks: Please mention the degree of craving +, ++ or +++

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

Would you like your cup of tea or coffee piping hot? Or just normal warm?

How many cups of tea / coffee do you generally take in a day?

Any aversion to any drinks?



**STOOL / BOWEL MOVEMENTS:**

Do you regularly have a satisfactory bowl evacuation?

How many times do you move the bowels? When?

Consistency : whether \_\_\_ Well formed \_\_\_ Semi-formed \_\_\_Very hard \_\_\_ Loose?

Odour

Colour of stools

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 stools 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 burning during urination?

Any difficulty in passage of urine?

Any smell (odour) in the urine?

Any difficulty in retaining urine? Do you have any incontinence while coughing or sneezing? Is the urine very urgent and you must rush immediately or it will escape?

Any associated complaints with urination?



**SEXUAL SPHERE**

**FOR MEN**

– Any sexual disturbances?

-- Excessive desire or aversion to sex

-- Disability of performance, premature ejaculation etc.?

-- Night emissions?

-- Any H/O Sexual abuse, excessive masturbation etc?

-- Any problem or complaints after intercourse?

**FOR WOMEN**

**MENSES**

Age of, appearance of first period (Menarche)?

How are the periods? – (regular or irregular)

What is the duration of your period and how many days cycle?

How is the flow? – (scanty, heavy, clotted, any odour, colour)

Any complaints associated with, before or after menses?

(e.g.: Headaches, irritability, pre-menstrual depression, diarrhoea or constipation).

Any heaviness or pain in breasts before menses?

Any nodules in the breast or any other pre-menstrual symptoms?

Do you experience any sexual disturbances?

Desire /aversion to coitus?

Any leucorrhoeal discharge?

(Character, colour, smell, when is it more?

Any Itching, burning or discomfort associated?)

Any sense, of weight or bearing down at the time of menses?



**PREGNANCIES**

How many times have you been pregnant?

How many children do you have and their age?

Did you have smooth pregnancies?

Did you take any medication during pregnancy?

Did you have normal deliveries?

**MENOPAUSE**

Age of menopause?

Any associated complaints at time of menopause?

e.g.: Hot flushes, palpitation, anxiety, depression etc



**PERSPIRATION (SWEAT)**

1. Do you perspire a lot?

2. Any particular part of the body, that you perspire more on?

3. Any strong/offensive odour associated (e.g. sour etc.) 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 of falling from a height, or being pursued by some men, or dead people etc.)

6. Does 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./enumerate type of skin lesion or eruptions or patches etc.)

2. Any itching, discolouration 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 skin around it?

6. Any complaint of Hair falling, early greying, dandruff, thinning etc.?

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

8. Does the 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

easliy)?



**GENERALITIES:**

**State how you are affected by or how you react to the following: (Are you aggravated or relieved by any of these?)**

1.Cold in general, cold air, drafts, cold winds etc.

1. Warmth in general, warmth of bed or of room, external warmth like hot formentation etc.
2. Weather; dry, cold wet weather, rains, cloudy etc.
3. Thunder storms
4. Open fresh air
5. Near the sea/on mountains
6. Movement/rest (do they worsen or help your problems)
7. Position/posture sitting, standing, lying on the back, rising, travelling.
8. Touch (slightest touch)
9. Pressing. Massage
10. Light (bright lights, glare/noise, smell etc.(e.g.: diesel, gasoline, fumes, pesticides)
11. Eating and drinking (before, during or after)

12a. Fasting

13. Any particular item of food/drinks which adversely affect you (or make you sick)

(e.g.: cabbage, cold drinks, eggs, fats, fruits, milk, meat, fish, prawns and onions,

potatoes, sour foods, pickles, sweets etc.)

14. Ascending or descending stairs

15. Closed, crowded places (e.g.: lifts etc.)

16. Emotional disturbances anxiety, grief, joy jealousy

17. Exertion or physical strain; mental strain

18. Lack of sleep

19. Company/solitude

20. Exposure to the sun

21. Bathing & washing, cold warm etc.

22. Sweating, passing urine, or stool

23. Clothing, covering

(e.g.: woolen, cotton, synthetic

tight clothing e.g.: high collars, ties).

24. In what part of 24 hours do you feel the best or the worst?

25. Do your troubles tend to occur or become worse, periodically?

(e.g.: daily on alternate days, every week, yearly, during new or full moon etc.



**THE MIND**

The peculiarities or symptoms of the body and the mind add up to make a complete individual.

The symptoms of the mind the way one feels, thinks interprets are essential to be taken into account to prescribe for the totality of the patient.(In order to evaluate these, some questions are formulated pertaining to the mental symptoms ) It is desirable to give detailed information instead of mere yes or no?

Have you noticed any marked changes in your mental state?

If so describe in detail

Have you become or are you-

1. Are you afraid of anything e.g.: being alone, animals, darkness, death, disease, thieves,

robbers, sudden noises etc. Please specify

2. Suspicious, doubting

3. a) Are you Impatient

b) Hurried, hasty

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

5. Are you over critical of others, always finding fault.

6. Irritable, quarrelsome, violent etc.

7. Depressed easily, sad, gloomy

8. Timid/shy, bashful

9. Diffident, proud

10. Are you Jealous?

11. Disgusted with life? Suicidal?

12. Indecisive; irresolute.

1. Indifferent or apathetic towards relatives, business or work, friends etc.

14. a) Anxious/Nervous

b) Restless/Excitable

15. Do you feel very anxious and apprehensive before examinations, before stressful situations,

public engagements etc.? Explain the situations when you are anxious.

16. a) Are you silent/quiet/reserved?

b) Are you talkative/make friends easily?

17. a) Are you very affectionate?

b) Do you demand love and warmth from others?

18. Do you cry easily - What makes you cry (grief of

others, music, kind words of affection etc.)

19.a) If someone consoles you when you are upset, does it help?

b) Does sympathizing with you makes matter worse?

20.a) Do you give vent to your worries, emotions etc.?

b) Do you bottle them up inside you or brood over them?

21. How do you stand and react to contradiction?

22. Any imaginary fears or feelings? (e.g.: that someone might want to harm you or

hurt you, that people are against you).

23. Do you often get startled or frightened easily? What causes it?

24. How is your memory, power of concentration and mental ability? Do you make mistakes in

speaking, writing etc.?

25. Do you regret anything in life or resent certain people. If so what and who and any reasons?

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

27. Are you seriously worried or unhappy over any personal, domestic, economical, social or any

other conditions? If so describe the situation in detail?

28. a) Are you over conscientious about details, cleanliness, tidiness , punctuality etc.?

b) Are you a perfectionist by nature, being meticulous, fastidious and even finicky?

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

have experienced?

30. 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.?

31. 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?

**PREVIOUS TREATMENT TAKEN**

|  |
| --- |
| Name of Disease Medicines Prescribed Systems of Therapeutics |

1.

2.

3.

4.

|  |
| --- |
| **Investigations Laboratory Tests X-Rays, Scans, MRI etc.** |

1.

2.

3.

4.