Dr Henry Kostecki
Doctor of Homeopathy

Patient Information (adult):

Today's Date: _____
Name: _____
Address: _____
Home Phone: _____
Work Phone: _____
Cell phone: _____

Email: _____
Birthdate: _____
Birth location: _____

Medications/ allergies/ vaccinations:

Medications currently taking:

_____
_____

Vitamins or nutritional supplements currently taking:

_____

Allergies to medications:

_____

Allergies to foods:

_____

Allergies to milk or dairy: _____

Did you have normal or no childhood diseases? _____

Did you have standard vaccinations? Any additional vaccinations?

_____

Main Complaints:

Food and Thirst:

Cravings: _____
Aversion: _____

Please resubmit to Dr. Henry Kostecki at hkostecki@gmail.com
1844 Susquehana Dr., South Lake Tahoe, CA 96150 **T:** 775-762-2899 **W:** drhenrykostecki.com

Do you crave sweet, salty, fatty, sour, spicy the most? *(List them in order from the most like to the least liked):* _____

_____

_____

How much water do you drink in a day?

_____

What temperature do you prefer your drinks?

_____

Do you drink coffee? If so, how much in one day?

_____

Do you drink alcohol? If so, how much?

_____

Stomach:

Any bloating, gas or other stomach problems?

_____

_____

Do you tend to have constipation or diarrhea?

_____

_____

How often do you have bowel movements?

_____

Sleep:

What hour do you go to bed and how long does it take to fall asleep?

_____

_____

Do you tend to wake up at a particular time each night and why?

_____

_____

Do you do anything in your sleep (speak, laugh, shriek, toss about, grind your teeth, snore etc.)?

_____

_____

Are you refreshed in the morning?

_____

What position do you sleep in?

Do you remember your dreams and is there a theme to them?

Do you have or ever had recurring dreams? If so, what are they about?

Women (answer all that apply):

Number of pregnancies / miscarriages / abortions?

What age did menses begin?

What age did menopause begin *(if applicable)*?

How often do you (or did you) get your menses?

Abundance of flow/ color of blood/ any clots?

How do you (or did you) feel before, during, and after menses (do you get PMS)?

Describe any discharges other than your periods
(Color, smell, abundance, texture and the time you get them the most)?

Have you had any chronic urinary infections or problems?

Have you had syphilis, gonorrhea, genital warts, herpes or any other sexual transmitted disease?

Men:
Do you have any burning with urination (after intercourse or anytime)?

Do you have any signs of prostate problems (frequent urination, difficult urination, or inflammation or enlargement of prostate)?

Have you had syphilis, gonorrhea, genital warts, herpes or any other sexual transmitted disease?

Sexuality:
Is your sexual desire above or below normal?

How do you feel about sex in general?

Do you consider yourself a sexual person?

How important is sex in a/your relationship?

Generalities:
What time of day tends to be the best/worst for you?

Do you tend to be chillier or warmer than others?

Are you sensitive to noises, smells or touch?

How sensitive on a scale of 1-100 are you to alcohol, drugs, medications, anesthesia, caffeine, foods etc? *(1 is not sensitive at all and 100 is so sensitive that you react to almost anything)*

_____

_____