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| --- | --- |
| Name, surname, birth date or ID , phone number, e-mail, adress, occupation |  |
| The main problem, symptoms and history |  |
| Aditional problems, symptoms and hystory |  |
| Diseases during life, operations, traumas |  |
| Congenital and chronic diseases in family |  |
| Pregnancy, delivery, menstruation cycle |  |
| Sleep, dreams |  |
| Fears |  |
| Peculiarity of character |  |
| Favourable and unlove food |  |
| Stool, urination |  |
| Perspiration |  |
| Skin problems during life |  |
| Reaction to weather condition |  |
| Previous traditional and homeopathic treatment |  |

Patients pre-consultation form.