**DR. SANKARAN’S CLINIC**

**CASE - RECORD**

**PLEASE READ THIS FIRST BEFORE FILLING THIS FORM**

You have come here to get well. We are here to select the possible medicine for you. In order to do that, we depend on your co-operation. HOMOEOPATHIC MEDICINE IS MAINLY SELECTED ON THE SYMPTOMS YOU GIVE US. If we are to make a successful prescription, we must know all the details of your sickness. We must also understand all the features that belong to you as an individual. This includes your reactions to various factors, your past and family history and your mental make up.

This information enables us to select the remedy that removes your sickness. The medicine also makes you well as a whole person.

In order find all about you, we shall be asking you many questions. Each one of these questions has a definite meaning and significance for us. There is not a single question that is useless. Even something that you may think is not connected with your trouble, may be the most important factor in deciding the correct homoeopathic medicine. *That is why you must be free and frank and give us the fullest possible information on each point*. Please read each question carefully, think, and if necessary, consult someone close to you and then answer completely. Do not keep anything back. Remember, whatever you tell us will remain absolutely confidential.

**THIS QUESTIONNAIRE HAS 8 PARTS :**

1. About your past illnesses. Please take time to answer this part with the help of your family members before coming to us.

2. History of your present illness.

3. About all the parts of your body.

4. Deals with the factors that affect your health. Please think carefully about each of the

factors mentioned and write what specific effects they have on you.

5. About your mental state and your emotional nature. Please write in this part about your situation in life and about all the things that are bothering you. Be totally frank and open.

6. About your sleep and dreams.

7. For children or how you were as a child.

8. In this part you are given instructions on how to report each of your complaints. Read the instructions first. Then make a list of your complaints and describe each of them according to the instructions.

1

**C O N F I D E N T I A L**

Date :

Name :

(Begin with Surname)

Address:

Telephone : Residence: Office:

Mobile:

E-mail: :

Age: Sex : Male / Female

D.O.B.:

Vegetarian / Non Veg. / Egg. Veg. Single/Married/Divorced/Widowed

Occupation (Nature of Work): Education: Referred to us by:

2

**PREVIOUS DISEASES & DRUG USED**

Every disease, poisoning, drug or accident leaves its mark and remains as a weak point in the system, much more than we imagine. Homoeopathic treatment takes into account all these details of the past and thus removes all the weak points. Thus your body is strengthened. Thus it is necessary for us to know about all the ailments you have suffered from in the past and the treatments you have taken.

In the list below, circle around names of ALL major illness so far suffered and on the next page give its relevant details.

|  |  |  |  |
| --- | --- | --- | --- |
| Typhoid  Cholera  Food poisoning Worms Diarrhoea Dysentery | Measles  German Measles Chicken-pox Small-pox  Mumps  Whooping cough | Malaria Jaundice Any Liver Spleen or Gall bladder disease | Miscarriage Abortion Currettings Sickness during Pregnancy etc. Prolapse of uterus |
| Malnutrition Rickets Rheumatism Backache | Any venereal disease like Syphillis Gonorrhoea etc. | Any heart trouble,  Blood pressure, Giddiness | Nephritis (Kidney or urine trouble) Diabetes etc. Prostate trouble |
| Any operation such as Tonsils, Abdomen, Appendix, Hernia, Piles Uterus, Renal stones, Gall stones, Phimosis, Hydocele, Cataract etc. Mode of anaesthesia : general-local | Diptheria, Septic Tonsils, Adenoids Recurrent infections-Sinusitis Bronchitis-Eosinophilia  Cold-Fever-Chill. Pneumonia  Asthma-Pleurisy-T. B. | | Any serious shock, grief, disappointments, fright, mental upset, depression or nervous break down. |
| Chronic Headaches, Numbness,  Cramps, Fits, Convulsions Polio, Paralysis etc. Meningitis -  Any Lumbar puncture done. | Any major accident or injury to body or head.  Any occasion of unconsciousness.  Any major bleeding from any part of the body. | | Skin diseases like Pimples, Boils, Carbuncles, Ringworms, Fungus, Scabies, Eczema. Herpes, Urticaria, Allergy. Ulcers on any part of the body. |

3

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Diseases suffered from | Approximate  Age | Duration | Whether you completely  recovered | Medicines & treatment taken | Any other particulars |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
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Any extra remarks or information

Mention any drugs, tonics, stimulants etc. that have been used by you at any time in life

4

**FAMILY INFORMATION**

***List of major diseases***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Relationship | Alive / Dead | Age | Diseases suffered | Cause of death |
| Paternal Grand Father |  |  |  |  |
| Paternal Grand Mother |  |  |  |  |
| Maternal Grand Father |  |  |  |  |
| Maternal Grand Mother |  |  |  |  |
| Father |  |  |  |  |
| Mother |  |  |  |  |
|  | Diseases suffered | | | |
| Paternal Uncle |  | | | |
| Paternal Aunts |  | | | |
| Maternal Uncle |  | | | |
| Maternal Aunts |  | | | |
| Cousin Brother &  Sister on Father’s Side |  | | | |
| Cousin Brother &  Sister on Mother’s Side |  | | | |
| Did any of your relatives have trouble similar to yours |  | | | |

Anaemia Cancer Diabetes Insanity Rheumatism

T. B. / Pleurisy Leprosy Epilepsy / Fits

Bleeding tendency

Urticaria Eczema Asthma Paralysis Hypertension Heart trouble Kidney disease

Liver disease etc.

\* How many brothers - sisters are you? (including those who died, if any)

Provide information about them in the table below, Indicate your position by writing ‘SELF’.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Sr. No | Brother / Sister | Alive / Dead | Age | Diseases Suffered |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |
| 4. |  |  |  |  |
| 5. |  |  |  |  |
| 6. |  |  |  |  |
| 7. |  |  |  |  |
| 8. |  |  |  |  |

\*About your birth :

**PERSONAL HISTORY**

Did your mother have any problem during pregnancy?

5

Did she take any drugs during pregnancy? What were they?

Was there any difficulty about your birth? Give Details.

\*At what age did you start.

|  |  |
| --- | --- |
| Urine control / bed-wetting etc. |  |
| Eating indigestibles like chalk, lime, earth,  slate-pencil etc. |  |
| Any other problem about your growth & development? |  |

|  |  |
| --- | --- |
| Teething |  |
| Sitting |  |
| Standing |  |
| Walking |  |
| Speaking |  |

Tick mark ( ü ) if any animal bites such as:

Dog Rat Snake Scorpion

Mention if any order:

Did you take anti-rabies or anti-venom or any other treatment?

6

\* Vaccination & Inoculations:

Indicate number of times you were vaccinated for the following:

|  |  |  |  |
| --- | --- | --- | --- |
| Small-pox | Polio | Cholera | Measles |
| Triple | B. C. G. | Typhoid | Tetanus |

Was there any reaction or particular trouble after any of above vaccination or inoculations? Give details:

(If married) How is the health of your husband/wife:

\* Number of children living and dead. If dead, state causes. Mention ages of children and their condition of health.

|  |  |  |  |
| --- | --- | --- | --- |
| Child’s Name | Male/Female | Age | Disease Suffered |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Any abortions, miscarriages or still births?

|  |  |
| --- | --- |
| Your Habits | How much? |
| Smoking |  |
| Snuff |  |
| Chewing tobacco |  |
| Alcohol |  |
| Tea |  |
| Sleeping Pills |  |
| Laxatives / Purgatives |  |
| Any other |  |

MAIN COMPLAINTS AND OTHER ASSOCIATED TROUBLES: (AND DETAILED HISTORY

OF THE PRESENT ILLNESS, THE ONSET AND COURSE WITH DATES).

**ORIGIN OF CAUSE :** Can you trace the origin of the present illness to any particular circumstance, accident, illness, incident or mental upset? (e.g. Shock, worry, errors in diet, overexertion, overexposure to cold, heat etc.)?

**APPETITE AND THIRST**

How is your appetite?

When are you hungry?

What happens if you have to remain hungry for long?

How fast do you eat?

How much thirst do you have?

Any particular time are you specially thirsty?

Do you feel any change in your taste and feeling in your mouth?

Please put one tick ( √) if you Like/ Dislike the food or if the food disagrees. Put two marks

( √√ ) , if you strongly Like / Dislike the food or if the food strongly disagrees.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Like | Dislike | Disagrees |  |  | Like | Dislike | Disagrees |
| Bitter |  |  |  |  | Eggs |  |  |  |
| Salt extra |  |  |  |  | Spicy food |  |  |  |
| Sweet |  |  |  |  | Meat |  |  |  |
| Sour |  |  |  |  | Fish |  |  |  |
| Bread |  |  |  |  | Cabbage |  |  |  |
| Butter |  |  |  |  | Onions |  |  |  |
| Fats |  |  |  |  | Warm food / drink |  |  |  |
| Milk |  |  |  |  | Cold food / drink |  |  |  |
| Coffee |  |  |  |  | Fruits |  |  |  |
| Mud / Chalk |  |  |  |  | Anything else |  |  |  |

**STOOL**

Do you have any problem regarding your stools?

When and how many times a day you pass stools? When is it urgent?

Do you have any problem about bowel movements?

Do you have to strain for stool? Even if soft?

Do you have belching or passing gas? Describe its character.

How do you feel after passing gas up or down?

**URINATION & URINE**

Any problem about urine?

Any strong smell? Like what?

Do you have any trouble before, during and after passing urine?

Any difficulty about the flow? Slow to start, interrupted, feeble, dribbling etc?

Any involuntary urination ? When?

**SWEAT / PERSPIRATION - FEVER - CHILL**

How much do you sweat?

Where and on what part do you sweat most?

Do you perspire on the palms or soles?

Is the sweat warm, cold, clammy, sticky, musty, greasy, stiffens the linen etc?

What is the smell like ? e.g. foul, pungent, sour, ruinous etc?

What colour does it stain the clothing?

Is the stain easy to wash off or difficult?

Any symptoms after sweating?

When do you get fever or chill? What brings it on?

Do you experience any sense of heat or cold in any part of your body at any particular time?

Do you have burning or heat in your palms or soles?

**CHEST - HEAT - COLD - COUGH**

Do you catch cold often? If so, how?

Describe the symptoms, nature of discharge etc.

Is there any trouble with your CHEST or HEART? Is there any trouble with your voice or speech?

Is there any difficulty in breathing?

Do you have cough?

Is it more at any particular time?

**SEXUAL SPHERE ( GENERAL )**

Any excessive indulgence in sex in past and present?

Any effect on your health?

How do you feel after sexual intercourse?

Any particular feeling or symptoms appear before, during or after sexual intercourse? Do you suffer from any sexual disturbance?

Any habit like (masturbation etc.) in past as well as present? How often?

Any homosexual inclination?

Did you suffer from any sexually transmitted disease? Syphilis? Gonorrhoea? Herpes? HIV?

Did you have increased desire or decreased desire for sex?

What is the method you use for family planning (contraception)?

**FOR MEN**

Any difficulty in erection?

Wanted erection ? Unwanted erection? Weak erection? Failing erection? Describe.

Any other trouble in sex? Describe in details.

**FOR WOMEN**

Menses : How are the periods; regular or irregular?

At what age did you start?

Was there any trouble then?

Mention interval between two periods.

Mention number of days of flow.

Menstrual flow: Is there any change now in quantity, colour, smell or consistency?

Are the stains difficult to wash?

Have you noticed any variation in quality and quantity of flow during menses? How and when?

Do you suffer in any way before, during or after menses? If so, describe:

What symptoms did you suffer during menopause?

Do you feel internal parts coming down?

Is there any white discharge?

If so, mention the nature, colour, consistency and smell of discharge.

When and under what circumstances is it more or less. Has the discharge any relation to menses?

What is the effect of this discharge on your general feeling? Or any of your symptoms?

Any itching, excoriation etc. due to discharge? Do you pass any gas from vagina?

Any trouble with breasts?

**ANY COMPLAINTS ABOUT:**

VERTIGO: Do you have giddiness - vertigo?

FAINTNESS: Do you ever feel faint?

HEAD: Do you get headaches ? EYES & VISION:

EARS & Sense of hearing: NOSE & Sense of smell : FACE & Facial expression:

MOUTH & Sense of taste:

About LIPS, MOUTH, TONGUE etc.:

TEETH,GUMS, e.g. carious teeth, bleeding gums. swollen gums.

LIPS: Cracked, peeling of skin etc.

THROAT ( including tonsils ):

Any difficulty in swallowing?

Do you have any trouble in your BACK, LIMBS OR JOINTS? Describe in detail:

If you have pains, do they shift?

In what direction do they extend?

Is there any abnormality, swelling, numbness, paralysis etc. in any part of the body?

Is there any complaint of SKIN : such as itching, eruptions ulcers, warts, corns, peeling etc.? (Describe its nature)

Any change in colour of the skin or spots of any part of the body?

Is there any complaint or abnormality of the NAILS or skins around?

Is there any complaint with the HAIR such as falling, graying, dandruff, dryness, oily, poor excessive or unusual growth?

Do wounds heal slowly?

Form keloid? Do wounds tend to form pus?

Have you a tendency to bleed?

Are your troubles one sided? Which one? Or more on one side?

Do they proceed from one to the other side ? Or do they alternate or shift?

Is there any trembling? When?

Is there any senses of weakness? Where? When is it more or less?

Is it in any particular part of the body?

**FACTORS THAT AFFECT YOU**

Below are the list of things that you are exposed to each of these factors may affect you in a particular way. Please write in what way you are affected by each of the following. Do you feel worse or better in any way from each of the factors. In what way do they affect you.

For instance take the factor “sun”. Suppose by going in the sun you get a headache then write “Headache” opposite to “Sun”.

Take another example If in hot weather you feel uneasy, then write “Uneasy” opposite to

“Hot Weather” in the column.

In this way write the effect of each factor on you. Especially write the effect each factor has on your main complaints. For instance if your main complaint is Asthma and this is worse when lying on the back then opposite to “lying on the back” write “Asthma becomes worse”.

Sometimes one factor may make you feel worse in some respect, and better in some other respect. For instance cold air may cause headache but make you feel better in general. If this is so, please mention this difference clearly.

This section is most important. Do not go through it hurriedly. Think carefully about the effect of each factor before you write.

|  |  |
| --- | --- |
|  | Effect |
| Walking |  |
| Running |  |
| Climbing stairs |  |
| Going downstairs |  |
| Riding in bus, car  etc. |  |
| Lying |  |
| Lying on back |  |
| Lying on left side |  |
| Lying on right side |  |
| Lying on abdomen |  |

|  |  |
| --- | --- |
|  | Effect |
| Hot weather |  |
| Cold weather |  |
| Rainy weather |  |
| Cloudy weather |  |
| Change of season |  |
| Thunder - storm |  |
| Covering |  |
| Warm bath |  |
| Sun |  |
| Cold bathing |  |

|  |  |
| --- | --- |
|  | Effect |
| Drinking |  |
| After sexual intercourse |  |
| Dust |  |
| Smoke |  |
| Touch |  |
| Pressure |  |
| Massage |  |
| Tight Clothes |  |
| Before Sleep |  |
| During Sleep |  |
| After Sleep |  |
| After afternoon nap |  |
| Loss of sleep |  |
| Before stools |  |
| During stools |  |
| After stools |  |
| Coughing |  |
| Sneezing |  |
| Laughing |  |
| Talking |  |
| Reading |  |
| Writing |  |
| Stooping |  |

|  |  |
| --- | --- |
|  | Effect |
| Lying with head low |  |
| Sitting |  |
| Sitting erect |  |
| Standing |  |
| Looking up |  |
| Looking down |  |
| Looking from high places |  |
| Looking from moving object |  |
| Noise |  |
| Sudden Noise |  |
| Music |  |
| Light |  |
| Strong smells |  |
| When constipated |  |
| Before Urine |  |
| During Urine |  |
| After Urine |  |
| Before Menses |  |
| During Menses |  |
| After Menses |  |
| After Sweating |  |
| When Fasting |  |
| After eating |  |

|  |  |
| --- | --- |
|  | Effect |
| Passing gas |  |
| After hair cut |  |
| Combing hair |  |
| Brushing teeth |  |
| Moonlight |  |
| Opening the mouth |  |
| Smoking |  |
| Hanging the limbs |  |
| Raising the arms |  |
| Near Sea |  |
| Shaving |  |
| Stretching |  |
| Swallowing |  |
| Listening to others  talk |  |
| Vomiting |  |
| Yawning |  |
| Moving the eyes |  |
| Opening the eyes |  |
| Closing the eyes |  |
| Getting feet wet |  |
| Over eating |  |
| Working in water |  |
| Fanning |  |

|  |  |
| --- | --- |
|  | Effect |
| Before important  engagement |  |
| Before exams |  |
| When angry |  |
| When worried |  |
| When sad |  |
| After Weeping |  |
| Consolation /  Sympathy |  |
| In a crowd |  |
| In a closed room |  |
| When thinking of  illness |  |
| Full Moon / New  Moon |  |
| Morning |  |
| Afternoon |  |
| Evening |  |
| Night |  |
| Bathing |  |
| Draft air |  |
| Biting or chewing |  |
| Blowing Nose |  |
| When alone |  |
| In company |  |
| Physical exertion |  |
| Belching |  |

**MIND**

It is now universally acknowledged that your mind has tremendous influence on your body. For giving proper treatment it is absolutely necessary for us to understand your emotional and intellectual nature. We can thus treat you as a whole.

In order to understand you we will be asking certain questions. Answer them freely, carefully and completely. This information will help us much in giving you the correct remedy. Also such a remedy will help improve your mental make up.

Answer freely. Answer frankly. Answer completely.

Are you anxious ? About which matters?

Are you fearful of anything such as animals, people, being alone, darkness, death, disease, robbers, sudden noises, thunder, of the future, of something unknown, high places, etc?

Are you doubtful or suspicious? Of what?

What are you jealous about?

Of whom? From what symptoms do you suffer when jealousy?

In which matter are you impatient? Hurried?

How long do you remember hurts caused to you by others?

How much revengeful are you?

What are you proud of? Does your pride get easily hurt?

Depress, Brooding, etc.?

Do you ever become suicidal? When?

If so in what manner do you contemplate to end your life?

Even then, are you afraid of dying?

When are you cheerful?

Are you sexual-minded?

Any unwanted thoughts any time?

What are they?

Have you any imaginary sensations or fears?

Do you hear voices, or that you are called, or anything else in this line keeps on

occurring in your mind unduly?

How is your memory?

For what is it poor? E.g. names, places, faces, what you have read, etc.

Do you weep easily?

What makes you weep?

How do you feel after weeping?

How do you feel if someone offers sympathy and consolation?

Are you easily irritated?

What makes you angry?

What bodily symptoms do you develop when angry? e.g. trembling, sweating etc.

Do you like company? Or like to remain alone?

How seriously are you affected by disorder and uncleanliness in your surrounding?

What are the greatest griefs that you have gone through in your life?

What are the greatest joys that you have had in life?

What activities you deeply like?

Are there any matters which you deeply dislike?

In your opinion, which aspects of your mind and moods are not agreeable to you? In spite of your awareness and maturity, are you unable to change these aspects?

Give a clear cut picture of your situation in life and your relationship with each of your family members, friends and associates in work.

How does the future look to you?

When you are free, what thoughts come to your mind?

Are you worried or unhappy over any personal, domestic, economical, social or any other condition?

If so describe in detail:

If asked for 3 desires or wishes in life, what will you ask for?

**S L E E P**

Describe your posture in sleep, on the back, side, abdomen etc.

Are you able to sleep in any position?

In which position you can’t sleep?

During sleep do you:

Snore? Grind teeth? Dribble saliva? Sweat?

Keep eyes or mouth open? Walk? Talk? Moan? Weep?

Become restless? Wake up with a jerk?

Describe if anything else is unusual about your sleep: (Sleepy, Sleeplessness, etc. if so when)

How much do you cover?

Do you have to uncover any parts?

Circle types of dream that you have

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Animals Cats - Dogs Horse  Wild animals  Snakes | Robbers Thieves Anxious Fearful  Ghosts | Travelling Riding Flying Swimming  Drowning | Houses Fruits Trees Water  Snow | Death, Whose? Dead bodies Dead persons Part of Body  Suicide |
| Being Hungry Being Thirsty Drinking  Eating | Fire Lightning Storm  Rain | Accidents Falling Shooting  Wars | Talking Singing Dancing  Pleasant | Business Money Day’s work  Forgotten work |
| Vomiting Passing stool Urinating  Blood-bleeding  Excrements /  soiling | Romantic  Sexual Pleasure  Rape  Nakedness | Pain Illness Sickness Mutilations | Praying Religious Temple Church God | Failure / Exams  Unsuccesful efforts ? For what ?  Missing Train  Being unprepared |
| Grief Weeping Vexation Quarrels Jealousy  Insults | Police Imprisonment Crime  Murder  Killing  Poison | Misfortunes Insecurity Danger  Being pursued  - By whom ?  - For what ? | If any other, specify in the space below: | |
| Of people Children Parties Feasts  Marriage | Of events Remote Recents Future  Prophetic | Physical Exertion  Mental Exertion  Fatigue |
| Coloured  Multi-Coloured |

Please draw something that comes to your mind at present or your favourite drawing:

FOR CHILDREN OR

YOU AS A CHILD (IN CASE OF ADULT)

1) Please tick mark once ( √ ) if the child or you as child had any of the following

qualities : Tick mark twice ( √√ ) if they are more intense :

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Tick here |  |  | Tick here |
| Obstinacy |  | Unusual fears |  |
| Temper tantrums |  | Shyness |  |
| Disobedience |  | Unusual attachments (to whom) |  |
| Aggression |  | Habits like :- |  |
| Hyperactivity |  | Biting nails |  |
| Destructiveness |  | Thumb-sucking |  |
| Courage |  | Picking and playing with |  |
| Possessiveness |  | (a) mother’s body parts |  |
| Competition - winning spirit |  | (b) shawls, handkerchieves |  |
| Slibling jealousy |  | (c) anything else |  |
| Any special skills |  | Religious |  |
| Unusual desires (for what) |  | Dullness of memory |  |
| Boasting |  | Slowness (in what) |  |
| Stealing |  | Laziness / Indolence |  |
| Telling lies |  | Sensitive / Emotional |  |

2) Please write in detail, if the mother suffered from any physical or emotional stress during pregnancy. Also describe the dreams the mother got during pregnancy.

3) Please describe any other aspects you feel are striking about the child.

4) Describe one incident from the child’s life when he/she very upset.

**HOW TO DESCRIBE YOUR COMPLAINTS**

In homoeopathy, prescription is based on precise details of various symptoms from which you suffer. To tell or write to a homoeopathic physician “I have a headache”, “an eruption”, or “cough”, would not be enough. If you inform him “I have headache with sharp shooting pains in the left side of the head and temple, these pains always come on when the slightest cold air strikes the head, the pains are much less when lying down and covering up the head warmly and much worse when rising up, walking about or when the head becomes cool”, then only you have given all the information required for making a good homoeopathic prescription. *The success of the prescription depends, largely, on how detailed is your description of the symptoms.*

We require the following details about your symptoms.

LOCATION : Please give the exact location of sensation, pain or eruption. Also describe

where the pain or sensation spreads. Please use the figure on page 24 to indicate location.

SENSATION : Express the type of sensation or the pain that you get in your own words however simple or funny it may seem. You may have a sensation that a mouse is crawling or the heart was grasped by an iron hand or you may have a pain which is cutting, burning jerking, pressing. Express the sensation or pain as it feels to you.

WHAT MAKES YOU WORSE OR BETTER : Many factors are likely to influence your trouble. Some factors may cause the trouble to increase and some factors may relieve the trouble. A detailed list of the factors is given on pages 14 to 16. Please refer to them when describing each of your troubles and indicate which factors make the complaint better or worse.

DISCHARGES : You may have a discharge from ulcers, fistula, eruptions the skin, lungs, eyes, nose, ears, mouth, private parts, etc. Please describe your discharge under the following aspects.

\* The quantity and the time or condition under which the quantity varies i.e. when is it better or worse, increases or decreases?

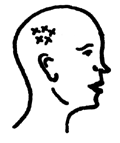
\* The consistency; Is it thin or thick, stringy, or clotted?

\* Is it like jelly, white of an egg, like water, sticky, forming a scab etc.?

\* The odour, what does it remind you of?

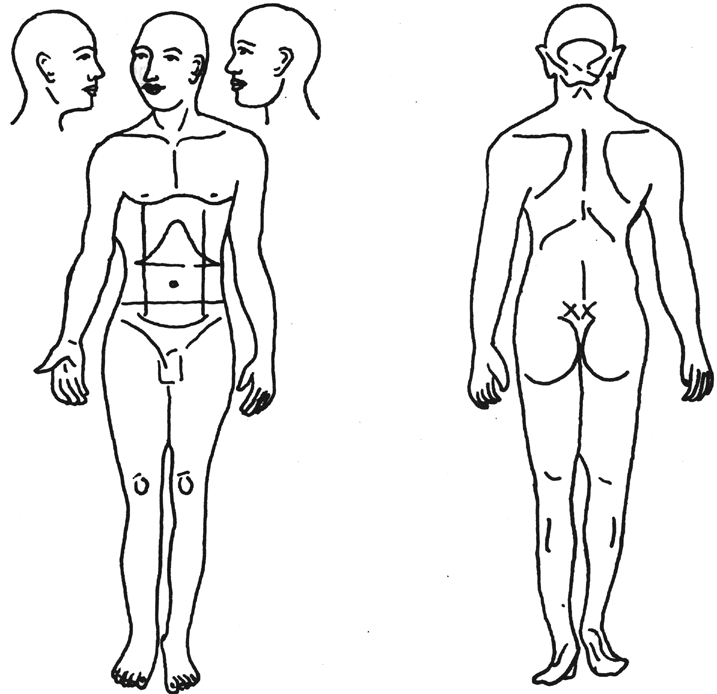
\* Does it make the parts sore, and in what way?

Please mark in the below figure, the locations of your trouble and write the exact sensation or type of pain you experience at those spots. For example if you have throbbing pain on the right side of you head please mark as shown



Throbbing pain

RIGHT FACE



FRONT

LEFT FACE

BACK

26

IN THE FOLLOWING PAGES PLEASE DESCRIBE EACH OF YOUR COMPLAINTS IN DETAIL IN THE MANNER DESCRIBED ON PAGE 24

|  |  |  |  |
| --- | --- | --- | --- |
| COMPLAINT NO. | WHERE IS THE TROUBLE | WHAT EXACTLY DO YOU FEEL OR HAVE THERE | WHAT ARE THE FACTORS THAT MAKE THIS TROUBLE BETTER OR WORSE |
|  |  |  |  |