Dr. Kumar Belgaumkar DMS, HD Doctor of Homoeopathic Medicine

PERSONAL INFORMATION

Name:_____
(Last) (First) (Middle initial)

Date of Birth: _____ Sex: ☐ Male ☐ Female
(Day) (Month) (Year) (Age)

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Number of Children:_____ Age(s):_____

Occupation / Employer:

CONTACT INFORMATION

Address:	Post Box #
City:	Province / State
Postal Code / Zip Code :	

Home Phone: Work Phone: Ext.

Cell Phone: E-mail Address:

REFERRAL INFO

How did you hear about us?

☐ Referral by individual - if so, whom may we thank? _____

☐ Yellow pages ☐ Website ☐ other:_____

101 - 1383 Pembina Hwy. Winnipeg, Manitoba R3T 2B9
Tel. (204) 284-7778 Fax (204) 284-9997
drkumarb@shaw.ca www.drkumarhomeopathy.com

PAST HEALTH HISTORY **Please check the condition(s) that are applicable to your present or past medical history.**			
☐ ABSCESSES	☐ ALCOHOLISM	☐ ANEMIA	☐ ARTHRITIS
☐ ASTHMA	☐ BACK PAIN	☐ BLEEDING DISORDER	☐ CANCER TYPE?:_____
☐ CHEMICAL DEPENDENCY	☐ CHEST PAIN	☐ CHICKEN POX	☐ CHRONIC FATIGUE
☐ COLD SORES	☐ CONSTIPATION	☐ DEPRESSION	☐ DIGESTIVE DISORDERS
☐ DIABETES	☐ DIZZINESS	☐ EATING DISORDER	☐ ECZEMA
☐ GALL STONES	☐ GOUT	☐ GENITAL HERPES	☐ HEADACHES
☐ HEART DISEASE	☐ HEPATITIS	☐ HERNIA	☐ HERNIATED DISC
☐ HIGH BLOOD PRESSURE	☐ HIV / AIDS	☐ INFECTIOUS DISEASES	☐ JAUNDICE
☐ KIDNEY DISEASE	☐ LEUKEMIA	☐ LYME DISEASE	☐ MALARIA
☐ MEASLES	☐ MONONUCLEOSIS	☐ MIGRAINES	☐ MUMPS
☐ PARASITES	☐ PLEURISY (FLUID IN THE LUNGS)	☐ PNEUMONIA	☐ PROSTATITIS
☐ PSORIASIS	☐ RHEUMATIC FEVER	☐ SINUSITIS	☐ STREP. THROAT
☐ STROKE	☐ SUN STROKE	☐ THYROID DISORDER	☐ TINNITUS RINGING IN EARS
☐ TONSILITIS	☐ TUMORS / GROWTHS / CYSTS	☐ ULCERS	☐ VENEREAL DISEASES (STIs)
☐ OTHER	☐	☐	☐

ANY OTHER INFORMATION YOU WOULD LIKE TO ADD:_____

_____

_____

PERSONAL MEDICAL HISTORY

Date of your last physical exam:_____

List all the surgeries you have had and date each occurred

Surgery	Date

List all the major accidents you have had (auto/falls/work) with the dates

Incident	Date

List all the stressful events you have experienced with the dates

Event	Date

FAMILY MEDICAL HISTORY		
Family member	Age	Health status
Mother		
Father		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		
Siblings		

Other information:_____

_____

_____

_____

_____

_____

PLEASE LIST ALL YOUR HEALTH CONCERNS TO BE ADDRESSED

Health Concern	Since

Health concerns - *continued*

Health Concern	Since

What diagnostic tests have you received for the health concerns listed?		
Diagnostic test	Date	Results
MRI		
CAT SCAN		
SCOPES		
BLOOD WORK		
ALLERGY TESTS		
OTHER		

LIST ALL THE PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS YOU ARE TAKING OR HAVE TAKEN		
Medication	Since	Reason

ANY OTHER INFORMATION REGARDING THE MEDICATIONS YOU ARE TAKING

_____

_____

_____

_____

LIST ALL THE SUPPLEMENTS / VITAMINS / HERBS / MINERALS YOU ARE TAKING		
Product	Since	Other info

ANY OTHER COMMENTS/HEALTH CONCERNS

_____

_____

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_____

WHAT ARE YOUR EXPECTATIONS OF HOMOEOPATHIC TREATMENT

_____

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