Klassische Homöopathie
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Patient form

Last name:
First name:
Date of birth:

Personal anamnesis

What was your development like in your childhood (teeth, first steps, speaking etc.)? Did you show any particular reactions after vaccinations? What events left a particular imprint on you?

Anamnesis of your family

What diseases (e.g. thyroid disease, lung conditions, asthma, tuberculosis, heart diseases, blood pressure problems, conditions of the locomotor system, diabetes, addictions, venereal diseases, tumours, epilepsy etc.) occur in your family (blood relatives like parents, grandparents, siblings, children etc.)?