**Restudy of your case/Review**

**Name of patient:**

**Age:**

**Gender:**

**Marital status:**

**Occupation:**

**Contact number & Email id:**

**Reference:**

**Diagnosis (including the year and month of diagnosis)**

**Reports if any (Recent and Previous reports findings)**

**Complaints in detail, including what makes it more or less, any relation to time, temperature, stress, position.**

**Origin/how complaints started ?**

**What were the exact initial symptoms ?**

**Relation of complaints in relation to TIME, FOOD, TEMPERATURE, OPEN AIR , POSITION/POSTURE, EATING, DRINKING.**

 **Effect of this problem on you, at emotional/mental/physical level.**

**How do you cope with a situation/how do you react/when your problems increase, then what do you like to do ? for e.g diverting the mind, walking in open air, sleeping ?**

**Any new observations from the time we met last and now?**

**(new observation in terms of physical or mental symptoms, from head to feet, any new food cravings/aversion). Sensation/Aggravating factor and ameliorating factor to the complaints.**

**Nature/state of mind**

**How do people around you describe you ?**

**Relationship with your spouse/mother/father/children**

**Situations which affect you mentally, emotionally.**

**What was the most stressful situation of your life ? amd what was your deeper experience in those situations ?**

**What are the things that you don’t like about yourself and you would like to change ?**

**Basic nature as a child and how was your childhood/ and childhood trauma ?**

**Relation with your parents and sibling during childhood.**

**Physical General**

**Desire/craving -**

**Any food allergies ?**

**Appetite/at what time you feel more hungry (hours/time)**

**How do you react to fasting ?**

**Thermally (which climate you are comfortable with it) -**

**Stool -**

**Urine -**

**Perspiration -**

**Sleep and sleep position -**

**Menses**

**Colour of menses**

**Duration of menses**

**Any clots?**

**Symptoms**

**Before menses**

**During menses**

**After menses**

**Any history of uses of contraceptive pills/other hormonal pills in past/steroids?**

**Sexual desire**

**(high, low, absent, if it is high, then any particular time when it is high - like before menses or morning time or night time)**

**Any pattern from the age of puberty till now ?**

**Dreams**

**(any pattern in dreams/any recurrent dreams)**

**Which books, Tv shows or autobiographies do you feel connected to ?**

**Addiction**

**(Alcohol, tobacco, drugs, mobile, tv, etc)**

**List of all the Homoeopathic remedies used.**

**Please mention the name & doses of allopathic medicines if you are using any**

**Currently.**

**Observation from your doctor**