

&

Research Centre

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**(Gold Medallist)** Chief Editor **– AKGsOVIHAMS**

**Monthly Newsletters**

Founder-Director **– AKGsOVIHAMS**

Om Vidya Institute of Homoeopathy & **Awards: -**

Allied Medical Sciences (Regd.) - Dr. Jugal Kishore Award

Accredited in: **Limca Book of Records -** Dr. Hahnemann Award - Appreciation Award

**Awards: - -** Meritorious Award

* Global Healthcare Excellence Award
* International Dr. Hahnemann Award of the Millenium **Clinics: -**
* Bharat Excellence Award ,Lord Dhanwantri Award 1. B-13, LSC, DDA Market, Shivaji Enclave
* Dr.Mohinder Singh Memorial Award; Meritorious Award; Rajouri Garden, New Delhi-110027,India
* Homoeopathic Gem Award; Chikitsa Ratan Award; Ph- 01142131989, 25430368, 7011842322

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PATIENT’S CASE PERFORMA FILE

NOTE: Homoeopathic Treatment is based on the Individual’s Detailed History and Maximum Information regarding the Symptoms of the Disease and the Patient. Unusual, Uncommon Peculiar Symptoms of the Patient are Most Important for the Constitutional Assessment which includes Mental Physical and Emotional details. As Homoeopathic treatment is individual based and not disease oriented only. So, furnish as much details as possible to achieve Cure of your problems.

Please upload all Medical reports like – Blood Reports, X-Rays, CT Scans, MRI, EMG,NCV etc.

Date:

Patient’s General Information

|  |  |
| --- | --- |
| Name: |  |
| Father’s/ Guardian’s Name: |  |
| AGE/Date Of Birth: |  |
| Sex: |  |
| RELIGION: |  |
| MARITAL STATUS:  Single /Married /Divorced |  |
| RESIDENTIAL ADDRESS: |  |
| COUNTRY: |  |
| Nationality: |  |
| Telephone No: |  |
| Fax No: |  |
| Mobile No: |  |
| E Mail Address: |  |
| Telephones: |  |
| Occupation / Nature of Work: |  |

**PRESENTING COMPLANTS (Main Problems)**

|  |  |
| --- | --- |
| What Is The Problem? | 1)  2)  3) |
| Explain - Causation / Onset Or Origin Of Each Complaint. (If Known) | |
| Site of The Problem? |  |
| When & How It Started? |  |
| How Has It Progressed? |  |
| Any Sensations? |  |
| Any Extension of Pains? |  |
| Modalities: (How Your Problem Gets Affected or Altered?) |  |
| **When & How Is It Worse or Better?**  (Time/Condition/Position/Season/Food Item, etc.) |  |

# **PAST HISTORY (Previous Diseases & Their Treatment)**

|  |  |
| --- | --- |
| **Any significant disease like :**  (Typhoid/Malaria/Jaundice/Measles/Tuberculosis/Allergies/Chicken pox etc.) |  |
| Hospitalization if any: (e.g. Accident/Disease /Any Surgical operation?) |  |
| Any problem of Diabetes/ Hypertension/ Arthritis/ Asthma etc. |  |
| Any treatment taken earlier, its duration and its outcome. |  |

# **FAMILY HISTORY**

|  |  |
| --- | --- |
| Any history of same suffering among Blood-related family members i.e. Parents Grandparents, Siblings, Aunts, Uncles and Cousins etc. from maternal or paternal side. Specify your relation with the person. | |
| **Any Family History of Diseases like :**  (Diabetes Mellitus , Thyroid / Obesity, Kidney Failure, Stones) |  |
| Arthritis like : (Gout/ Osteo Aarthritis / Rheumatoid Arthritis) |  |
| Tuberculosis : (Cancer /Malignancy) |  |
| Hypertension : (Heart Problem / Angina / Coronary Artery Disease) |  |
| Skin Disease : (i.e Psoriasis / Vitiligo / Eczema / Urticarea) |  |
| Asthma/ Allergic Bronchitis / Sinusitis / Hay Fever |  |
| Anxiety Neurosis/ Depression/ Psychiatric & Mental Disorders / Schizophrenia , Epilepsy / Paralysis/ Stroke |  |
| Gonorrhoea /Syphillis or STD/ AIDS, Any Genetic problem, or any other Sickness not mentioned. |  |

# **PERSONAL HISTORY & GENRALITIES**

|  |  |
| --- | --- |
| ( Kindly elaborate and mention habits, addictions like Alcohol, Smoking, Tobacco etc.) | |
| **Allergies :** (If any (Known or Unknown Allergens specially Any Drug / Food Allergy ) |  |
| Tendencies : ( like Cold, Viral, Infections, Boils etc.) or any other |  |
| Smoking : (If Yes - How many and since when ?) |  |
| Drinking Alcohol : (If Yes - quantity, duration and frequency) ? |  |
| Any Other Addictions ?  (Tobacco/ Paan Masala/ Drugs etc ?) |  |
| Temperature : ( Normal/Subnormal/ Raised) ? |  |
| Blood Pressure? |  |
| SLEEP: Whether restless/ disturbed/ sound/ position during sleep ? |  |
| DREAMS: (Whether regular / occasional. Type of Dreams – Pleasant/ Unpleasant/ Frightful/ Day to day affairs/ Animals/ Snakes/ Water / Journey/ Accidents / Death / Dead people/ Sexual – Wet dreams/ Past Events/ Loss or missing something Heights/ Failure / Night Mares etc |  |
| Do you wake up because of dream / Are you able to sleep again easily afterwards / Do you have to make efforts to go to sleep again / Does the same dream continues again? |  |
| Do you normally remember / forget the dream?  What is the effect of Dreams on you the following  Day? |  |
| APETITE: Whether hunger is proper or not, any food substance allergic to or it suits or does not suit? |  |
| THIRST: How is your Thirst? Please mention the grade of thirst? If you are very thirsty, you may mention grades +, ++ or +++ (Quantity, frequency, liking for cold or normal, or thirstlessness ) ? |  |
| DESIRE or CRAVINGS: (Mention grades of preference +, ++ or +++ For example if you like sweets, mention + or ++ or +++) Sweets, Salty, Sour, Fried, Spicy, Cold or Hot /, Tea, Coffee, Milk, Fruits, Eggs, Meat, Fish, Alcohol etc.) |  |
| Anything else Unusual like Mud, Chalk, Pencils etc, Does it cause any problem? |  |
| AVERSION or DISLIKE to any like Sweets, Salty,  Sour, Fried, Cold or Hot, Bread, etc. or any thing in particular like Meat/ fish/ egg/ milk/ vegetables/ chocolates etc. Or anything else |  |
| URINE (frequency, character, color , pain /burning, involuntary urination, stress incontinence, any complaints before/during or after urination - Any Blood, Sediments etc ? |  |
| STOOL: (frequency, Bowel movements, constipation, loose/hard, any complaints before/during or after stools. Any Mucus or Blood in stool. Any pain /burning while passing stool ? |  |
| SWEATING - (More /Less / Normal. Summers/Winters .Any particular part. Where you sweat more , Odour or Smell of sweat does it stain the clothes ) |  |
| Does your trouble tend to occur or become worse, periodically (e.g daily or alternate days, Weekly, Monthly, and Yearly, during New or Full Moon etc?) |  |
| THERMAL REACTION: (Feel Heat / Cold more, Sensitivity/tolerance, any coldness of the Hands/Feet.) |  |

# **MENTAL STATE (The Mind)**

|  |  |
| --- | --- |
| (It’s very important to give as much details as possible in this section especially in chronic diseases ). | |
| Do you like to be Alone or in Company ? |  |
| Any Fears or Phobias (of being alone/darkness/heights/death/ water/ falling/ghosts/ thunderstorms/ animals /thieves / robbers / sudden noises or any other things .) Specify |  |
| How is your temperament ? (Irritable/ Weep easily/ Sensitive/ get Angry soon / Depressed./Moderate/ Accommodating / Cool.) |  |
| If angry : (What brings the anger, and what do you do – Shout / Abuse / Violent / Don’t show and Suppress or something else - Specify ) |  |
| Do you weep easily ? Yes /No  (Do you weep when alone or in front of others ?  How do you feel after weeping?) |  |
| What is the effect of consolation on you ? |  |
| Do you share your feelings with others or keep inside you ? |  |
| How about taking Decisions – Indecisive / Take quick decisions and stick on them or Wavering ? |  |
| Jealous/ Suspicious/ Religious/ Superstitious, if yes, then of what and to what extent? |  |
| How about keeping things Neat and Tidy /clean ? Any Fault finding in others ? |  |
| **Do you worry a lot ?** Yes / No  (Even for small things / or take things lightly ) |  |
| Do you Brood over things ? Yes / No  (How does it affects you ?) |  |
| Anxiety if any about (What / when/ what happens when you have anxiety/ does it associate with any physical problems.(Sweating/Trembling/Palpitation/ Breathlessness, Sinking etc. Pls.specify). |  |
| Do you get startled easily by sudden noises , telephone bells, banging of doors etc ? |  |
| Are you very caring by nature or indifferent ? (Towards family members and friends etc.) ? |  |
| How do you feel when Contradicted ? |  |
| Any Guilt or Regrets in life? |  |
| Do you Apologies or Not? |  |
| Any Negative or Suicidal thoughts? (Explain and if Yes , any such Attempt made. |  |
| How Ambitious are you? |  |
| Any Non fulfillment of ambition in life ? |  |
| Do you like your work ? or don’t want to do it. |  |
| What do you think about your disease? |  |
| Do you forgive easily? Keep the bad things done to you in mind and plan to give it back when time comes Revengeful/ Coward/ Brood. |  |
| Any Complex about yourself ? |  |
| Do you hurry for everything and become Impatient? |  |
| Do you Postpone the things or become worried with Anticipation ? |  |
| How do you rate yourself ? ( Self Esteem, Haughty, Shy, Rational, Egoistic, Sympathetic, Conscientious, Emotional, Strong Headed, Calculative, Impulsive etc.) |  |
| What according to you others think of you ? |  |
| What makes you feel Happy ? |  |
| What makes you feel Sad ? |  |
| Please mention any Incidence, Mishap , Loss, Betrayal , Death, Disappointment , Love, Insult, Failure, Depression etc. which has any impact or relation to your present problem either has affected you deeply or otherwise also. | |

# **SEXUAL HISTORY**

|  |  |
| --- | --- |
| **Any history of Venereal Diseases** (e.g – Gonorrhoea , Syphllis, Herpes , AIDS.) |  |
| **Sexual Behaviour :** (Single / Multiple Partners; Bi Sexual ; Homosexual ; Gays; Indulgence ; frequency ; Masturbation etc.) |  |
| **Any Problem like:** (Impotency; Pains; Erectile Dysfunctions ; Premature Ejeculations Partial or Complete loss of interest in sexual activities Specify if any other problem ?) |  |
| Desire / Dislike/ Hate to Inter Course / How does Sexual activities affect you ? |  |
| Any persitent sexual thaughts / dreams / fanatsises. |  |

### Gynecological History for Women

|  |  |
| --- | --- |
| Any Sexual disturbance? |  |
| Menses | |
| **Menarche** (At what Age did the 1st Menses appear)? |  |
| **Menopause:** Age when menses stopped. Any complaints/symptoms associated with it. |  |
| Date of Last Menstrual Period? |  |
| **Menses :** (Regular / Irregular /Early /Late /Painful Non  Painful?) |  |
| **Duration of cycle:** (After how many days you get your periods.) |  |
| **Duration of flow:** (For how many days the Bleeding remains). |  |
| **Character of flow :**  (Thin/Fresh/Clotted/ Intermittent/ Dark/ Bright Red/ Black/ Stringy / Irritating ) |  |
| **Amount of flow :** Scanty/Less / More /Profuse |  |
| **Odour :** Offensive/ Strong Smelly/ Normal |  |
| **If Painful Menses**:(location and character, Is it Continuous or Spasmodic?) Breast pain or hardness of the breast. |  |
| When does it start, any relation of pain with flow of blood. How does the pain Increases or Decreases? |  |
| **Any other symptom associated** (e.g. Headache, Backache, Vomiting, Vertigo, and Faintness etc.  Vaginal Itching). |  |
| **Leucorrhoea / Watery Discharge:** (Thin / Thick/ Stringy; Scanty / Moderate / Profuse; Irritating / Burning /Bland; Color – White/ Transparent / Milky/ Yellow/ Bloody etc. Smell – Offensive / Non Offensive; Staining / Non Staining. |  |
| **Intermenstrual Bleeding :** (Yes / No) |  |
| **Any PMT:** (Pre Menstrual tension)? Do you have any complaints associated with, before, or after menses? e.g. Moods Swing , Headache, irritability Anger Weeping Depression Diarrhea or Constipation |  |
| Any change in your skin around menses? |  |
| Contraceptive History: - Oral Pills/ IUCDs/ Tubectomy & the effects thereafter |  |

**OBSTETRICAL HISTORY: (Mothers - Pregnancy, Deliveries & Child bearing)**

|  |  |
| --- | --- |
| How many times have you been pregnant? |  |
| How many Children do you have and their age? |  |
| Year of Ist and Last Delivery & state whether Normal, Forceps or Ceasarian? |  |
| **Labor Pains :** Normal/ Induced/ Short/ Prolonged |  |
| **Any ailment during pregnancy:** (e.g. Blood Pressure, Vomiting, Fever, Diabetes etc. & Treatment taken during Pregnancy). |  |
| Any Complaint After Delivery: - Fever, Thyroids, Convulsions etc. Lactation ( Milk Feeding) |  |
| **Abortion if any** (specify the cause) - MTP/ Threatened/ Miscarriage. In which month of pregnancy? |  |
| **Effects after abortion:** Irregular Periods/excessive Bleeding/Menses Stopped/Pains etc. |  |

## **CHILDHOOD HISTORY( Must for a CHILD patient )**

|  |  |
| --- | --- |
| Type of Delivery: (Normal / Forceps / Ceasarian/ Congenital Abnormality /Any other Complication.) |  |
| Mother’s Antenatal History | |
| Physical Health |  |
| Emotional Aspect |  |
|  | |
| Immediate Post Natal Period: (Cry / Jaundice / Convulsions / Any Resuscitation measure) |  |
| Breast Feeding up to the age |  |
| Artificial /Bottle Feeding upto the age |  |
|  | |
| Mile stones of Development ( mention the age of starting ) | |
| Teething |  |
| Speech |  |
| Walking |  |
| Immunisation / Vaccinations History : (Complete /Partial /No vaccination at all. Any reaction or effect after the Vaccination). |  |
| BCG , DPT, MMR, Chicken Pox, Hepatitis, Meningitis , Typhoid , Boosters, Any Other |  |
| Any history of eating of Mud / Chalk/ Pencils / Paper / Clothes etc. |  |
| Any history of Worms ? |  |
| History of Bed Wetting : Thumb Sucking, Nail Biting |  |
| History of Temper : Tantrums , Any Behavioral problems |  |

# **GENERAL PHYSICAL APPEARANCE**

|  |  |
| --- | --- |
| Built (Strong, Thin, Stout, Obese, Average). |  |
| Nutrition: (Well nourished, Undernourished or over nourished) |  |
| Height and Weight: |  |
| Swelling or Growth/ Tumor – If any ? |  |
| Skin: (Dry/Rough/Smooth/Oily/Greasy/Pigmentation) |  |
| Hair: (Texture etc.) |  |
| Nails: |  |
| Teeth: |  |
| Fever: (If have fever, when, any periodicity, particular time, duration of fever, if feel chilly/ hot/ sweat/ duration of each phase; any time modality, thirst, tongue, headaches, nausea, vomiting, thirst, appetite, body aches, restlessness if any.) |  |
| Please mention any thing else pertaining to you and your problem which you feel has not been asked in the Questionare and is persistent and unusual, Do mention strange feeling if any. (All histories, Case reports are kept Confidential) | |
| Photos can be attached if required. | |
| *( Signature )* | |

Instructions

In view that the patients world over, who have chronic diseases resistant to conventional line of treatment be able to take advantage of homeopathic treatment, we at A.K.Gs OVIHAMS (A.K.Gs Om Vidya Institute of Homoeopathy & Allied Medical Sciences) have devised a special method to treat these patients from a long distance. It is case history that is more important to us in such chronic conditions, hence after receiving patient's detailed case history in a format, he can be treated successfully even without being present in the clinic physically.

It is very simple to have on-line consultation from our Medical centre !

**Steps for receiving Online Consultation**

* Firstly, ask your query to Dr A.K. Gupta by sending a mail to **askdrgupta@ovihams.com ;drakgupta@ovihams.com.**
* When you decide to receive the treatment, you pay the necessary charges by mail transfer or bank draft or by other way.
* You will receive an email with username and password of the control panel where you can send the queries and receive the answers and suggestions from Dr. A.K. Gupta
* You also have to fill the Case Performa and attach the file or send it by email at **drakgupta@ovihams.com**
* Your case will be worked with expertise manner and medicines would be couriered to you on mailing address given by you. Patients from most parts of the US and Europe get the medicine within 10 to 15 days.

**CHARGES**

In order to promote homeopathy world over, the treatment offered on-line is at a small token cost. Charges may be different in certain chronic and difficult cases like MND etc. depending on the Medications.

* Above charges include Consultation charges, Medicine charges and Courier charges for that respective period within India only. Postage / Courier Charges for Overseas is additional.
* Charges are subject to change.

Modes of Payment

ICICI Bank A/c No. 629301506782

IFSC Code : ICIC0006301

Swift Code : ICICINBBNRI

Vishal Enclave, Uttam Nagar, New Delhi Branch

Or

PayPal A/c – [drakgupta@ovihams.com](mailto:drakgupta@ovihams.com)

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