Health Information and History

Name ____ Date __________

Home Address ____ Zip ___________

Phone________________________ DOB ________________ Age _______

Occupation ____

Marital Status _______________ Children & Ages (if applicable)_______________________________

What are your primary objectives in seeking an Ayurvedic consultation?

~Please note that *Ayurvedic Consultations do not include medical diagnosis and treatments*. If you are concerned about a medical condition you should see a medical doctor~

____

____

____

Please describe your primary concern(s). How long has this troubled you?

____

____

____

Additional conditions that are currently challenging, such as: aches, pains, stress, digestive disturbances, fatigue, poor mental clarity, concentration, vision, depression, hot flashes, chills, sleep habits, anxiety, etc.

____

____

____

Height ___________ Weight ___________ Weight Fluctuation?________________

What prescription drugs or medications are you currently taking? *(how often, how much, how many years)*

____

____

Herbal & vitamin supplements____

Smoking____

Drinking alcohol____

Recreational / Non-prescription Drugs______________________________________

What surgeries have you had and when?____

____

____

Are you currently under a physician's care for a specific medical problem or condition? Yes No

If yes, for what? ____

FEMALES: Pregnant _______ Number of Months ______ Number of previous births ________

Difficult past pregnancies _________ Complications _______________________________

Birth Control ▫ yes ▫ no What Type ______________ How long ______

Date of Last Menstrual Period _____ Length of cycle ________________ Cycles: ▫ regular ▫ irregular

Days between cycles _________________ Flow: ▫ heavy, ▫ med, ▫ light

Clots: ▫ yes ▫ no Pain/difficulty during cycle _______________________________

PMS symptoms ____

Any other symptoms during cycle ______________________________

Yeast infections ____

Urinary tract infection (UTI) (frequency, duration) ____________________

Menopausal stage / symptoms ________________________________

MALES: Prostate Condition __________________________ Other ______________

____

Personal History

Do you or your family members have a history of: (check the boxes that apply)

	Myself	Family Member			Myself	Family Member	
		Maternal	Paternal			Maternal	Paternal
Allergies to Food	☐	☐	☐	Stroke	☐	☐	☐
Allergies to Drugs	☐	☐	☐	Cerebro Vascular Accident	☐	☐	☐
Dental Treatment Complications	☐	☐	☐	Cancer	☐	☐	☐
Bleeding Gums	☐	☐	☐	Chemotherapy	☐	☐	☐
Contact Lenses	☐	☐	☐	Radiation Treatment	☐	☐	☐
Glaucoma	☐	☐	☐	Hepatitis A	☐	☐	☐
Eye Surgery	☐	☐	☐	Hepatitis B	☐	☐	☐
Pain in the Ear	☐	☐	☐	Hepatitis Non-A / Non-B	☐	☐	☐
Ringing in the Ear	☐	☐	☐	Mononucleosis	☐	☐	☐

Shortness of Breath	☐	☐	☐	Jaundice	☐	☐	☐
Asthma	☐	☐	☐	Anemia	☐	☐	☐
Pneumonia	☐	☐	☐	Gallstone	☐	☐	☐
TB	☐	☐	☐	Kidney Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐	Kidney Stones	☐	☐	☐
Low Blood Pressure	☐	☐	☐	Bladder Disease	☐	☐	☐
Dizziness	☐	☐	☐	Thyroid Condition	☐	☐	☐
Fainting	☐	☐	☐	Thyroid Medication	☐	☐	☐
Seizures	☐	☐	☐	Ulcers	☐	☐	☐
Convulsions	☐	☐	☐	Intestinal Bleeding	☐	☐	☐
Epilepsy	☐	☐	☐	Chronic Constipation	☐	☐	☐
Diabetes	☐	☐	☐	Recurring Diarrhea	☐	☐	☐
Feet or Ankles Swelling	☐	☐	☐	Arthritis	☐	☐	☐
Chest Pain	☐	☐	☐	Implant	☐	☐	☐
Angina	☐	☐	☐	Prosthesis	☐	☐	☐
Heart Murmur	☐	☐	☐	Prolonged Bleeding When Cut	☐	☐	☐
Heart Attack	☐	☐	☐	Psychiatric Treatment	☐	☐	☐
Heart Disease	☐	☐	☐	Venereal Diseases (STDs)	☐	☐	☐
Heart Surgery	☐	☐	☐	HIV Exposure	☐	☐	☐
Rheumatic Fever	☐	☐	☐	Sleep Disorders	☐	☐	☐

Any other family illnesses? ____

Exercise: Do you currently engage in any exercise or physical activity? __________________________

____

Have you ever done Yoga postures before? ___________ If so, what type, how often? _____________

____

Diet: Please list a *typical* day's diet, including snacks, beverages and what time you eat the meals/ snacks listed:

Breakfast:____

____

____

Lunch:____

____

____

Dinner:____

____

____

Snacks / additional beverages (and what

time):____

____

____