Date:

PATIENT HISTORY QUESTIONNAIRE

(Answer after reading every topic carefully & then Email this filled form on iambhandari@yahoo.com)

All questions contained in this questionnaire are strictly confidential and will be used only for Dr. Bhandari's Ayurvedic Consultation & Diet-Life style Guidance.

Name (Last, First, M.I.):	**M/F**	**Age:**
Marital status: Single Partnered Married Separated Divorced Widowed		
Body Weight 1 year Old/ Recent (Kg.)	**Height** (Feet - Inches)	
Date of last physical exam:		
Occupation (Type - Number of Hours working):		

BODY - MIND CONSTITUTION - DOSHA TYPE (IF YOU KNOW ABOUT IT)

Vataj Pittaj Kaphaj Vata-Pitta Pitta-Kapha Vata-Kapha

PERSONAL HEALTH HISTORY

Major Illness in Life:	Measles Mumps Rubella Chickenpox Rheumatic Fever Polio Chronic Cold Tonsillitis	
Immunizations and dates:	Tetanus	Pneumonia
	Hepatitis	Chickenpox
	Influenza	MMR *Measles, Mumps, Rubella*

List (with details)-the medical problems or concerned symptoms that you want Dr. Bhandari to help you with.

Surgeries you had in Life

Year	Reason	Hospital

Other Hospitalizations in Life

Year	Reason	Hospital

Have you ever had a blood transfusion? (If yes, then- How many times?)	Yes	No

List your prescribed drugs and over-the-counter drugs (Vitamins and Inhalers) that you are taking or had taken.		
Name of the Drug	Strength of the Drug	Frequency Taken (from last days/months)

Allergies to Medications (if ever in Life)	
Name of the Drug	Particular Reaction You Had

DIET – LIFE STYLE AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise Routine	Sedentary (No exercise)					
	Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet Routine	Are you dieting?				Yes	No
	If yes, are you on a physician prescribed medical diet?				Yes	No
	# of meals you eat in an average day?					
	Rank salt intake	Hi	Med	Low		
	Rank fat intake	Hi	Med	Low		
Beverages/ day	☐ None	Coffee -	Tea -	Cola -		
	Number of cups/cans per day?					
Alcohol Intake	Do you drink alcohol?				Yes	No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				Yes	No
	Have you considered stopping?				Yes	No
	Have you ever experienced blackouts?				Yes	No
	Are you prone to “binge” drinking?				Yes	No
	Do you drive after drinking?				Yes	No
Tobacco Intake	Do you use tobacco?				Yes	No
	Cigarettes – pcks./day		Chew - #/day	Pipe - #/day	Cigars - #/day	
	Number of years	Or year quit				

Addictions or Drugs	Do you currently use recreational or street drugs?	Yes	No
	Have you ever given yourself street drugs with a needle?	Yes	No
Sexual Life	Are you sexually active?	Yes	No
	If yes, are you trying for a pregnancy?	Yes	No
	If not trying for a pregnancy list contraceptive or barrier method used:	Yes	No
	Any discomfort with intercourse?	Yes	No
Living Style	Do you live alone?	Yes	No
	Do you have frequent falls?	Yes	No
	Do you have vision or hearing loss?	Yes	No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father				M F	
Mother				M F	
	M F			M F	
	M F			M F	
	M F		**Grandmother** *Maternal*		
	M F		**Grandfather** *Maternal*		
	M F		**Grandmother** *Paternal*		
	M F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	Yes	No
Do you feel depressed?	Yes	No
Do you panic when stressed?	Yes	No
Do you have problems with eating or your appetite?	Yes	No
Do you cry frequently?	Yes	No
Have you ever attempted suicide?	Yes	No
Have you ever seriously thought about hurting yourself?	Yes	No
Do you have trouble sleeping?	Yes	No
Have you ever been to a counselor?	Yes	No

WOMEN ONLY		
Age at onset of menstruation:		
Date of last menstruation:		
Period every days		
Heavy periods, irregularity, spotting, pain, or discharge?	Yes	No
Number of pregnancies Number of live births		
Are you pregnant or breastfeeding?	Yes	No
Have you had a D&C, hysterectomy, or Cesarean?	Yes	No
Any urinary tract, bladder, or kidney infections within the last year?	Yes	No
Any blood in your urine?	Yes	No
Any problems with control of urination?	Yes	No
Any hot flashes or sweating at night?	Yes	No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	Yes	No
Experienced any recent breast tenderness, lumps, or nipple discharge?	Yes	No
Date of last pap and rectal exam?		

MEN ONLY		
Do you usually get up to urinate during the night?	Yes	No
If yes, # of times		
Do you feel pain or burning with urination?	Yes	No
Any blood in your urine?	Yes	No
Do you feel burning discharge from penis?	Yes	No
Has the force of your urination decreased?	Yes	No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	Yes	No
Do you have any problems emptying your bladder completely?	Yes	No
Any difficulty with erection or ejaculation?	Yes	No
Any testicle pain or swelling?	Yes	No
Date of last prostate and rectal exam?		

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

Skin	Chest/Heart	Recent changes in:
Head/Neck	Back	Weight
Ears	Intestinal	Energy level
Nose	Bladder	Ability to sleep
Throat	Bowel	Other pain/discomfort:

Lungs Circulation