**SREEKRISHNA AYURVEDA CHIKITSA KENDRAM**

HEALTH QUESTIONAIRE

 D.O.A: ................. D.O.D: ................ OPNO: ................. IP NO: ........................................

###  Name of Doctor in charge: ................................................................. Department:................................................

 Name of the patient:..................................................................................................................................

 Age................................... Gender: M/F, Religion:...................................:......................... ......................

 Birth details:

Time of birth:....................Date of birth:...............................Place of birth...................................... country of birth:…………………………………………….

Nature of birth: Normal /Assisted/ Caesarean. Full term / Premature / Delayed.

State of health at birth : Good / satisfactory/ disturbed

 Countries lived for long term with duration:.............................................................................................

 Current Address: .......................................................................................................................................

 .....................................................................................................Tele .NO................................................

 Marital status: ............ .......................................................NO. Children with age:.................................

 Educational status:......................................................................................................................................

 Occupation with duration:.........................................................................................................................

 Nature of job with number of hours per day: ..........................................................................................

 ......................................................................................................................................................

 Nature of regular travel: ............................................................................ Duration of travel: ...............

 Frequency of travel:...............................................................................................................................

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ROGA PAREEKSHA -- EXAMINATION OF DISESASE

Present complaints: Describe nature of symptoms in the chronological order from when you were

Apparently healthy? Mention the year from which you have these complaints? Also mention what Factors aggravate or relieve each of your symptoms?

 Medical history:

 Have you consulted anybody else for the same? What were the treatments given?

 Do you suffer from any other chronic diseases? In which year you were diagnosed?

Do you have history of : Diabetes Hypertension Hyperlipidemia

Liver diseases Kidney diseases Gall bladder diseases

Epilepsy Heart diseases Migraine

 What are the Medications you are taking now?

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 Please describe if you had any serious injuries/accidents?

 Did you under go any operations? Yes....... No...........

 List them with year in which you underwent?

 Family History: Father Age: ........... Country of origin ...................... medical history................................

 Mother age:.................................. country of origin.............................. medical history.................... .. ..

 Siblings No:.......................... Important medical history..............................................................................

**Do you suffer from the following symptoms ?**

Disinterest in food distaste in mouth no taste sensation

 Nausea heaviness of body drowsiness

Whole body ache fever black out

Anaemia blockage of channels tiredness

Weight loss poor digestion early wrinkling & grey hair

Skin eruptions bleeding disorder excessive menstrual bleeding

Mouth ulcer ulcers in private parts enlarged **spleen / liver**

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 Tumour warts nodes

 Abnormal growths

MENSTRUAL HISTORY

How is your menstrual bleeding?

Quantity

Scanty \_\_\_\_\_ normal \_\_\_\_\_ Excess \_\_\_\_\_\_\_\_

Colour

Bluish \_\_\_\_\_\_\_ Yellowish \_\_\_\_\_\_\_ Blackish\_\_\_\_\_\_ Pale\_\_\_\_\_

Pain

Premenstrual \_\_\_\_\_\_\_ during menstruation \_\_\_\_\_\_ postmenstrual\_\_\_\_\_\_

Associated with

Burning sensation \_\_\_\_ White discharge \_\_\_\_\_ sounds like flatulence\_\_\_\_

Itching \_\_\_\_\_\_ bad smell \_\_\_\_\_\_\_ frothy blood\_\_\_\_\_ clots\_\_\_\_\_

Length of cycle \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Length of bleeding\_\_\_\_\_\_\_\_\_\_\_\_

When is your next period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take the pill or any contraceptives? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**AHARA (FOOD)**

Do you cook your food or eat outside? -------------------------------------------------------------------

What do you eat? Vegetarian? ---------------------No vegetarian? ----------------

At what time do you take your meals?

Breakfast ----------------------------lunch--------------------------------- dinner ---------------------------

Do you feel hungry?

Breakfast - yes no Lunch - yes no Dinner yes no

Which is your main meal?

Breakfast ------------------------ Lunch ------------------------------------- Dinner ------------------------

Are you hungry in between? Yes No

Do you snack in between meals? Yes No

If yes what do you snack? -------------------------------------------------------------------------------------

What is your usual diet?

Breakfast ---------------------------------------------------------------------------------------------------------

-------------------------------------------------------------------------------------------------------------------------

Lunch -----------------------------------------------------------------------------------------------------------------

-------------------------------------------------------------------------------------------------------------------------

Dinner ----------------------------------------------------------------------------------------------------------------

--------------------------------------------------------------------------------------------------------------------------

Quantity of food intake less -------normal -------- much --------

Are you allergic to certain food? Yes ------- no --------

If yes, to what kind of food? ------------------------------------------------------------------------------

Did you change your diet or eating habits on recommendation of your physician or friends?

Yes ....... no ........How and since when? ----------------------------------------------------------------

DRINK

How is your thirst? Very good -------------- normal ------------------ bad ----

What do you drink with meals? --------------------------------------------------------------------------------

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**VIHARA (lifestyle)**

**SLEEP**

How is your sleep? Very good (deep) -------- bad (light) ------------dreamy-------

 Disturbed /waking up in between -----------------

 Very short /less hours of sleep --------- excess sleep ----

 Snoring --------------- walking in sleep ----------- day sleep

 How long do you sleep? -----------------------------------------------------------------------------------------

At what time do you go to sleep? ----------------------------------------------------------------------------

At what time do you get up? --------------------------------------------------------------------------------

How do you feel when you wake up? ------------------------------------------------------------------------

Fresh --------- Tired ------------ Heavy ---------- Aches --------- Stiff ----------- with urge for stool

And urine ----------- digestive disturbances -------------------------------

**STOOL**

Frequency ------------------------- When -------------------------------

Formed ---------------- dark ----------- dry -------------- hard --------------------- floting --------

Soft, loose ------------ yellowish --------- with smell ---------- sinking -------

Soft, formed-------------- pale ------------ sticky -------------- drops --------

Pellet like ---------------- undigested food in stool ------------

Do you have alternating constipation – loose stool? ---------------------------------------------------

Traces of blood in stool? -----------------------------------------------------------------------------------------

History of haemorrhoids /Piles? ------------------------------------------------------------------------------

**URINE**

Colour: light ------------------------ yellow -------------------- dark --------------------------

Frequency in the night -------------------------------------------------------------------------------------------

Any difficulties in urination? -----------------------------------------------------------------------------------

What are your usual morning regiments?

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**EXERCISE / SPORTS**

Are you doing any sports? Yes no

What kind of sports? ---------------------------------------------------------------------------------------------When ---------------------------------------------------------------------------------------------------------------

Duration ------------------------------------------ frequency per week ---------------------------------------

Do you practice yoga meditation Tai chi or similar? ------------------------------------------------------

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BATHING /SHOWER

How many times do you take a bath a day? ----------------------------------------------------------------

When ----------------------------------------------------------------------------------------------------------------

HABITS

Have you used any narcotic drugs? Regularly............... occasionally .................never................

 If yes what drug......................................................................................................................

For what duration regularly ---------------- occasionally ---------------- never-------------

Do you smoke? Regularly ---------------- occasionally ---------------- never--------------

When do you smoke? --------------------------------------------------------------------------------------------

How many cigarettes a day -------------------------------------------------------------------------------------

Do you drink alcohol? Regularly --------------------- occasionally ---------- never ------------------

When do you drink? ---------------------------------------------------------------------------------------------

How much do you drink? ---------------------------------------------------------------------------------------

 **(PTO)**

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**PURPOSE OF TREATMENT**

**SREEKRISHNA AYURVEDA CHIKITSAKENDRAM**

**CHIEF PHYSICIAN‘S NOTE**

**ROGI PAREEKSHA – EXAMINATION OF PATIENT**

Clinical findings: (leave this space for your doctor to write)

Dars’ana Spars’ana Pars’na

Tongue Pulse Urine

Eyes Touch Stool

 Built

 Voice Blood Pressure

 Weight Height Auscultation

Description of the affected area