Three Rivers Ayurveda-Patient Medical History

Name: _____ DOB: _____ Date: _____

As a new patient, we first would like you to answer the questions below so that we can get an idea of your past medical history. On page 5 of this form, you will have an opportunity to write a "free-write summary" in which you can tell us your story in your own words.

Present Age: _____ Height: _____Ft _____ Inches Present Weight: _____

Blood Type and Rh Factor (if known): _____

Are you currently under the care of any providers of alternative medicine? YES ☐ NO ☐

Practice Type: _____

Provider Name: _____ Phone Number: _____

If in the past you had seen providers of alternative medicine/healers, please list the type of work they did (e.g. Acupuncture, Reiki, Energy Healing, etc.): _____

_____

Are you allergic to any medications? YES ☐ NO ☐
If yes, please list the names of the medications and your reactions to them:_____

_____

Are you allergic to any materials or foods? (Example: Latex, Cat Dander, Peanuts)
If yes, please list the substances and your reactions to them: _____

_____

Do you drink alcohol? How often? _____

Do you use Smoke? YES ☐ NO ☐ Former Smoker, Quit in year:_____

If yes, how many packs per day?_____ For how many years? _____

Do you have a present or past history of:

☐Y ☐N Anemia. If yes, list type:
☐Y ☐N Arthritis. If yes, list type:
☐Y ☐N Asthma
☐Y ☐N Depression
☐Y ☐N Anxiety
☐Y ☐N Autoimmune Disorders. If yes, list type:
☐Y ☐N Cancer.
☐Y ☐N COPD
☐Y ☐N CHF
☐Y ☐N Congenital Heart Disease
☐Y ☐N Coronary Artery Disease
☐Y ☐N Diabetes. If yes, circle type: Type I Type II
☐Y ☐N Eczema
☐Y ☐N Glaucoma
☐Y ☐N Inflammatory Bowel Disease
☐Y ☐N MI/Heart Attack
☐Y ☐N Heart Arrythmia
☐Y ☐N Heart Murmur
☐Y ☐N Heart Valve Disorder
☐Y ☐N Hepatitis or Liver Disease
☐Y ☐N High Blood Pressure
☐Y ☐N Hypothyroidism
☐Y ☐N Hyperthyroidism
☐Y ☐N Hay Fever/Seasonal Allergies
☐Y ☐N Lyme's Disease
☐Y ☐N Migraines
☐Y ☐N Multiple Sclerosis
☐Y ☐N Pacemaker
☐Y ☐N Peptic Ulcers
☐Y ☐N Psoriasis
☐Y ☐N Rheumatic Fever
☐Y ☐N Seizure Disorders
☐Y ☐N Sleep Apnea
☐Y ☐N Stroke or Transient Ischemic Attacks
☐Y ☐N Tuberculosis
☐Y ☐N Prolonged Steroid Therapy or other Immune Deficiency State?
☐Y ☐N Issues with Prolonged Bleeding?

Please circle if you have been diagnosed with any of the following: Irritable Bowel Disease, Chronic Fatigue/CFIDS, Fibromyalgia, or Environmental Sensitivity

Any other issues?

_____

_____

Please list any past surgeries you have had:

_____

_____

Please list any hospitalizations that you have had (do not include visits to the ER):

_____

_____

FAMILY HISTORY: Has any one in your immediate family had any of the following? Write the relation of the relative on the line (e.g. brother, sister, mother, etc.)

☐ Diabetes:_____
☐ Coronary Artery Disease:_____
☐ Hypertension:_____
☐ Substance Abuse:_____
☐ Neurological Disease:_____
☐ Inflammatory Bowel Disease:_____
☐ Heart Attack before age 50:_____
☐ Cancer: _____
☐ Stroke: _____
☐ Peripheral Artery Disease:_____
☐ Other: _____

Please list all current doctor-prescribed medications: **Name, Strength, Dosage**
(Example: **Name:** Metformin **Strength:** 1000mg **Dosage:** One pill twice daily)

_____

_____

_____

_____

_____

_____

_____

_____

Please list all current herbal or alternative supplements: **Name, Strength, Dosage**
(Example: Arnica 30X, 5 pellets 3 times daily)

_____
_____
_____
_____
_____
_____
_____

Please list all herbal/alternative supplements that you have taken in the past and no longer take:_____
_____
_____
_____
_____

Please list all over-the-counter medications you are currently taking: **Name, Strength, Dosage.**
(Example: Tylenol 500 mg, 1 pill every 8 hours)

_____
_____
_____
_____
_____

For Women:
If sexually active, what is your method of birth control? _____
Number of pregnancies:_____ Number of Live Births:_____
Age when periods started: _____ Age when periods ended (if applicable):_____
Are your periods regular or irregular? _____
Pain or heavy bleeding during periods?_____
Premenstrual Symptoms?_____

“FREE WRITE” AREA

What is the primary reason for this consultation? What are the most important things about you and your life that you feel I should know about? Feel free to include a summary of your history, your current diet and lifestyle, or anything you feel is pertinent. You can also use this space to continue answering any of the questions from the history form above.

Printed Name:_____ Signature:_____ Date:_____