

ATREYA AYURVEDA CLINIC AND PANCHAKARMA CENTRE

For online consultation ayurvedasant@gmail.com

mobile- 9845840792

**PLEASE FILL IN THIS FORM FOR OUR CHIEF PHYSICIAN
TO RESPOND TO YOUR AILMENT**

Name of the patient:

Guardian's Name :
(In case of a minor)

Address and Postal code :

Mobile :

E-mail ID :

Age :

Sex :

Height :

Weight :

Structure
(Obese/Medium/Lean) :

JOB DETAILS

Nature of work and whether it involves traveling

PRESENT COMPLAINTS

List of present complaints with duration of each

SNo	DESCRIPTION	DURATION
1.		
2.		
3.		
4.		
5.		

6.		
7.		
8.		
9.		
10.		
11.		

Full History of present complaints:

Details of investigations done so far:

Upload lab, X-ray, CT scan, MRI scan images and report (each image should not be more than 4MB)

Details of treatments done:

Current Medication:

Allergies:

History of previous illnesses: (Option)

Past Medical History

DISEASES	YES	NO
Malaria		
Diabetes		
Fileria		
Jaundice		
Piles		
Fistula		
Ulcer		
Aneamic		
Heart disease		
Cancer		

OTHERS	
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Inpatient Treatment Required	YES / NO

STATE OF DIGESTION

APPETITE	Normal / Less / More
BOWEL HABITS	Regular / Irregular
URINE QUANTITY	Adequate / Less / More
SLEEP	Adequate / Less / More / Disturbed

MENSTRUATION

CYCLE	Regular / Irregular
FLOW	Normal / Less / More
ASSOCIATED WITH	Pain / Clots / Muscle cramps
MARITAL STATUS	Married / Unmarried

Delivery: Problems if any

DIETARY HABITS	Vegetarian / Non Vegetarian	
SCHEDULE	MENU	TIMINGS
EARLY MORNING		
BREAK FAST		
MID MORNING		
LUNCH		
EVENING		
NIGHT		
ADDICIONS IF ANY	Smoking / Alcohol / Tobacco chewing	

Others please specify: