

**Application for
Health and Well-Being Consultation**

With

Vaidya Mishra

www.vaidyamishra.com

1 (888) 9 SHAKTI

Date:

Please print entries

LAST NAME	FIRST	MIDDLE	HOME PHONE		WORK PHONE
OCCUPATION			SEX	AGE	MARITAL STATUS
BIRTHDATE					
HOME ADDRESS					
How did you hear about Vaidya Mishra or this consultation service?					
Do you have any present complaints regarding your health? If so, please specify:					
When and with whom was your last physical exam?					
Has any relative (parent, brother, sister, children, other) had or do any now have:					
(Check each item)			NO/ YES ?	Relationship	
Asthma, Hay fever, Hives					
Cancer					
Diabetes					
Epilepsy					
Heart Attack at a " Young" Age					
High blood pressure					
Arthritis					
Tuberculosis					
Kidney disease					
Alcoholism, drug abuse, mental illness					

What prescription medicines or other remedies do you occasionally or regularly take? (Include hormones, birth control pills, vitamins, herbs, over-the-counter drugs, etc.)

Cups of coffee/tea per day? _____ Never smoked Smoking now _____ Packs/day Used to smoke _____ Packs/day
 Cups of soda per day? _____ _____ years _____ years

On average, how much alcohol do you consume per day?

None occasionally only 1-2 drinks daily 3-4 drinks daily more than 4 daily

Present weight _____ Eating disorder? _____

Have you experienced a recent gain or loss in weight?

If yes, how many lbs? _____ Over what period of time? _____

Have you ever had, or have you now? (Please check each item):

	No	Yes	Year		No	Yes	Year
Headache (recurrent)				Sugar in urine			
Head injury				Albumin in urine			
Eye trouble				Get up nights to urinate			
Worn glasses or contacts				Swollen or painful joints			
Ear, nose, or throat trouble				Back pain			
Sinusitis				Rash			
Cough				Reaction to serum, drug, or medicine			
Cough up blood				Hay fever or allergy			
Shortness of breath				Dizziness or faintness			
Asthma				Paralysis			
Tuberculosis				Depression or excessive worry			
Lived with anyone who had tuberculosis				Insomnia			
Pain or pressure in chest				Drug or narcotic use			
Palpitation or pounding of heart				Appendicitis			
High blood pressure				Goiter or thyroid problems			
Heart murmur				Epilepsy			
Severe tooth or gum trouble				Complications of childhood diseases			
Indigestion				Scarlet fever			
Gall bladder trouble or stones				Rheumatic fever			
Jaundice				Tumor, growth, cyst, or cancer			

Persistent or recurrent diarrhea				Venereal disease			
Hemorrhoids or rectal disease				Duodenal ulcer			
Painful urinations				Menstrual problems			
Blood in urine				Anemia			
Kidney stone				cancer			
PMS							

MENSTRUAL HISTORY:

Age at onset		Interval between periods (days)		Duration (days)		Date of last period	
Anything unusual about your period?							
Do you regularly have gynecological checkups including PAP smear?							
When was your last checkup?							

CHECK EACH ITEM:

NO YES

Have you ever been denied life insurance or rated up because of your health?		
Have you ever worked with radioactive substances? If so, state where and when		
Have you ever had radiation treatment?		
Have you ever been advised to have an operation? If so, please list details below		
Have you ever had a serious illness? If yes, please describe below		
Have you ever had serious injuries (fractures)? If yes, please describe below		
Are you concerned about having or contracting AIDS?		
Are you having any sexual problems?		
Are you having any job or family problems?		
Please list all operations, hospitalizations, and serious illnesses:		
Were you a victim of childhood physical, sexual, or psychological abuse?		
Are you currently in psychotherapy?		
Have you taken medication for anxiety, depression, or mental problems in the past?		

*In the event of a serious medical condition, Vaidya Mishra reserves the right to defer this consultation.