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PRESENTATION OF DATA FOR AYURVEDIC HEALTH ANALYSIS BY DOCTORS' PANEL

To: **Whom It may Concern**

Dear Sir / Madam,

READ this carefully once and then fill out.
All information is kept strictly confidential.

Please attach additional information including medical reports if relevant:

Guest's Input

Name:	
Gender:	
Date of birth:	
Age:	
Day time phone number:	
Day time phone number:	
Mobile:	
Address:	
Occupation:	
Marital status:	
Number of children with their age:	
Height in cms /feet inches:	
Weight in stone/ kilos:	
Time period you can stay in an Ayurvedic retreat (give dates if possible):	
Main aim in visiting an Ayurvedic retreat:	
Visiting alone or with company:	

Chief Complaints		Duration
1		
2		
3		
4		
5		

History of	Tick	Duration
Diabetes		
Heart Disease		
Hypertension		
Hypercholestrimia		
Joint diseases		
Stomach complaints		
Respiratory disease		
Liver disease		
Skin allergy / disease		
Hay Fever / Sinusitis		
Eye disease		
Ear disease		
Hemorrhoids		
Renal (kidney) diseases		
Sexual weakness		
Epilepsy		
Giddiness		
Swelling		
Thyroid problems		
Urinary disease		
Injuries		
Headache		
Uterine fibroid		
Ovarian cyst		
Intestinal disease		
Numbness		
Gas accumulation		
Any other previous illness		

Are you currently taking any medication? If yes, give particulars with dosage:	

Food items you are allergic to and reaction:	
Food items you avoid and why:	
Food cravings:	
Do you usually / occasionally / frequently get bloating / gas / cramps after eating / when you don't eat properly / even when you eat properly?	
Other important symptoms you have noticed related to your digestion are:	

Recent Blood Test Results:
Date of test:

- Hb
- TWBC
- Polymorph
- Lymphocyte
- Easinophils
- ESR
- Blood Sugar FBS
- Blood sugar PPBS
- S. Cholesterol
- SGOT (AST)
- SGPT (ALT)
- Lipids Profile
    - Triglycerides
    - Total Cholesterol
    - HDL
    - LDL
    - VLDL

Use this section only if you are female.

Have you had caesarians?
Are your menstrual periods regular?

Do you get PMT?:
Do you get clots?:
Do you get cramps?:
Do you get extreme fatigue?:
Do you use tampons or pads?:
Details of miscarriages:
If you have been trying to fall pregnant, for how long?

Signature:

Date: