... because *GOOD* medicine ... works ...!

Health & Medical History

PLEASE COMPLETE ALL 6 PAGES FOR YOUR CONSULTATION WITH DR. BHATTACHARYA.
PLEASE keep a copy for your records.

Name : _____ **Today's DATE**_____ **Current Place of Residence** _____
Date of Birth : _____ Place of Birth _____ Age _____

How would you rate your current health? _ Excellent _ Good _ Fair _ Poor

PRESENT HEALTH CONCERNS:
What concerns would you like to address in this holistically-oriented visit?
How long have you experienced these conditions?
1) _____ _____
2) _____ _____
3) _____ _____
4) _____ _____

In order to change these conditions, how willing are you to make dietary and lifestyle modifications?
very willing / somewhat willing / not very willing
Please list any other major health concerns in your life, past or present:

_____ _____
_____ _____
_____ _____

PAIN SCALE: severity: 1 2 3 4 5 6 7 8 9 10 where in body? _____
duration: how often _____ every day? _____ how many weeks/years? _____
what makes it worse / better? _____

TYPES OF HEALTH PROVIDERS YOU VISIT (incl herbalists, acupuncturists, nutritionists, MDs, MTs) :

_____ _____
_____ _____
When and where did you last receive medical or health care? _____

HEIGHT _____ **WEIGHT** _____ **BLOOD TYPE** _____
Highest weight ever: _____ Year _____ Lowest weight as an adult: _____ Year _____

When during the day is your energy the best? _____ worst? _____
How is your appetite? Never Hungry Medium Wavers Very Hungry or Very Full Always Hungry

What did you eat yesterday? _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Recent Test Results that Concern You:

_____ _____
_____ _____

Address:_____

Home phone:_____ Work phone: _____ Cell phone: _____

E-mail address:_____

PERSONAL MEDICAL HISTORY:
Please indicate **your** own experience with any of the following medical problems (include dates):

___ Heart disease
___ Alcoholism
___ Bleeding/clotting problem
___ Heart attack
___ Blood transfusion
___ Thyroid problems
___ Diabetes *specify type* _____
___ Cancer (Malignancy) _____
___ Stroke
___ Addiction→ *specify type* – *sugar alcohol nicotine marijuana*
___ Gut/Belly problems
___ High cholesterol
___ High blood pressure
___ Depression/suicide attempt
___ Chronic headaches

Other problems (specify): _____ _____
_____ _____

SURGICAL & HOSPITAL HISTORY:
Please list all prior operations and hospitalizations (with dates):

_____ _____
_____ _____

Where and when have you lived or traveled outside your main country of residence?

_____ _____ _____
_____ _____ _____

What cravings do you have and how often? _____ _____
_____ _____ _____

MEDICATIONS/HERBS: Prescription & non-prescription medicines, vitamins, home remedies, birth control pills, herbs

Issue	Medication	Dose (eg.mg/pill)	When / if each day	When started

Do you currently take or use?

Laxatives	Y N	Pain relievers	Y N	Antacids	Y N	Other _____	
Cortisone	Y N	Appetite suppressants	Y N	Antibiotics	Y N	_____	
Tranquilizers	Y N	Thyroid medication	Y N	Sleeping Pills	Y N	_____	

HYPERSENSITIVITY, ALLERGIES or REACTIONS TO MEDICINES: _____
ALLERGIES or REACTIONS TO FOODS: _____

Which of the following **IMMUNIZATIONS** have you had:
Hepatitis A_____ Hepatitis B _____ Influenza _____ Measles_____ Pneumovax (Pneumonia)_____ Rubella _____ Tetanus (Td)____ Varicella (chicken pox) _____

When were your most recent **HEALTH MAINTENANCE** screening tests:
Mammogram _____ Results? _____ Stool test for blood _____ Results? _____
- Ever abnormal? _____ Details: _____ Sigmoidoscopy: _____ Results? _____
(Females) Pap smear: _____ Results? _____ (Males) Prostate cancer screen _____ Results? _____
- Ever abnormal? _____ Details: _____ Cholesterol Screening _____ Results? _____

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MIND AND SPIRIT

What are you afraid of these days? _____

What supports you when you fall? _____

IN AND OUT: HOW YOU PROCESS FOOD

How often are your **bowel movements**? Every day once/ Several times a day / Once every _____

Frequency: Regular Irregular

Color: white yellow mid-brown has blood dark-brown black _____

Shape: Long like a banana like a pencil in pieces has stringy pieces like pellets_____

Density: Floats Floats, then sinks Sinks _____

AAMA EVALUATION:

In the past 7 days, have you felt any of the following symptoms (mark +++, ++, +, 0) :

Symptom	Sat	Sun	Mon	Tues	Wedn	Thurs	Fri
Passing gas							
Bloating							
Acid reflux							
Watery BM							
Bellyache							
# of BMs							
Fatigue							
Fog-headed							

Which of the following symptoms do you have ?

V : constipation gas anxiety fear desire for warmth

P : acidity body heat burning irritability desire for cold

K : indigestion heaviness loss of appetite desire for pungent or astringent foods

Outcomes Measures: What will change in your life to let you know you are feeling well?

Now (unwanted symptom) _____ Then (optimal health) _____

Now _____ Then _____

Now _____ Then _____

Now _____ Then _____

Now _____ Then _____

FOODS THAT YOU PREFER TO EAT:

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FAMILY HISTORY:

What is your heritage? With which cultures or countries do you identify yourself? _____

Any other relevant family history? _____

Please indicate the current status of your immediate family members:

	Alive or Deceased	Age (now or at death)	Cause of death
Mother	_____	_____	_____
Father	_____	_____	_____
Sister (total #___)	_____	_____	_____
Brother (total #___)	_____	_____	_____
Child #____	_____	_____	_____
Child #____	_____	_____	_____
Other _____	_____	_____	_____

Please indicate whether any family members have had any of the following conditions and detail:

Medical Condition	**Mother**	**Father**	**Sibling**	**Sibling**	**Child**	**Child**
Alcoholism						
Anemia						
Arthritis						
Asthma / Hay fever						
Autoimmune Disorder						
Bleeding problem						
Cancer of the Breast						
Cancer of Colon						
Cancer/Skin Melanoma						
Cancer of Ovary / Prostate						
Heart Attack (Coronary Artery Disease)						
Birth Defects (eg Down Syndrome)						
Depression						
Diabetes, Type 1 (childhood onset)						
Diabetes, Type 2 (adult onset)						
Eczema						
Epilepsy (seizure disorder)						
Food Allergies / Gut problems						
Hearing problems / Glaucoma						
High Cholesterol						
High Blood Pressure / Stroke						
Kidney diseases						
Osteoporosis						
Migraine Headaches						
Substance abuse						
Thyroid disorders						
Chronic Tobacco User						
Other -						
Other -						

Have you completed your ADVANCE DIRECTIVES form? (circle) Yes No What are they...?
Do you have a DURABLE POWER OF ATTORNEY / HEALTH CARE PROXY? Yes No

LIFESTYLE CHOICES/ SOCIAL HISTORY:

please circle your answers and be as open as you can

Caffeine Consumption: None
Sodas: ____oz./day Chocolate_____oz./day
Coffee Espresso Tea _____cups/day

Weight Are you satisfied with your weight? No Yes
What do you feel is your optimal weight? ___

Nutrition How do you rate the way you eat? Good Fair Poor
Do you eat food to nourish or to comfort yourself? ____
Do you take Supplements? No Yes (list them on p.1)
Do you take CALCIUM supplements? No Yes

Exercise: Do you exercise daily? No Yes
What types of movement do you give yourself?
yoga running gym sports housework gardening walking

List the types of exercise you get in a typical week:
Type _____ How often _____ How long _____
Type _____ How often _____ How long _____
Type _____ How often _____ How long _____
If you do not exercise, why? _____

Intimacy & Sexual Activity
Do you engage in physical intimacy with someone?
No Yes Not regularly
Are you comfortable with issues of intimacy
about your own body? No Yes
Do you enjoy sex? No Yes
Current sex partner(s) is/are: male female both
Birth control method: _____ none needed

Tobacco Use Cigarettes: Never Quit: Date____
Pipe Cigar Snuff Chew
Current Smoker: packs/day____ #of years____
Do you eat/use _ Paan _ Bidi _ Kola Nuts _ Cacao
Are you interested in quitting? _No _ Yes

Alcohol Use
Do you drink beer? No Yes # beers/week___
Do you drink wine? No Yes # wine glasses/week___
Do you drink Liquor? No Yes # drinks/week___
Is alcohol use a concern for you or others? No Yes
Drug Use Do you use any recreational drugs? _No _ Yes
Marijuana _ Cocaine _ Heroin _ Other:_____
Have you ever used needles for drugs? _ No _ Yes
Do you want to be tested for Hepatitis or HIV? _ No _ Yes

Violence
Is VIOLENCE at home a concern for you? No Yes
Have you ever been ABUSED? No Yes
Would you like to talk about surviving abuse? No Yes
Have you ever had any sexually transmitted
diseases or infections (STDs)? No Yes _____
Are you interested in being screened for
sexually transmitted diseases? No Yes

Do you engage in mental/emotional intimacy with someone?
No Yes Not regularly
Who supports you? _____

Pets Do you have a pet? Animal _____ Name _____

Work/ Career Occupation:_____ Employer:_____
Goals for Career in the next 3 years: _____
Education: Highest Level of Formal Schooling _____
Home Who takes care of your home? _____
Marital Status: Single Partnered Married Divorced Widow/er Satisfied Not currently satisfied
Name of Spouse / Partner: _____ Number of children / ages:_____
Who lives at home with you?_____ Do you like your home? No Yes

For women: # pregnancies: ___ # deliveries: ___ # abortions:__ # miscarriages:___
1st day of most recent period: _____ How many days did it go? ____
Age at 1st period: ____ Frequency of periods: _____ Do you have any concerns about menopause? _ No _Yes: _____
Do you have any concerns about your periods? _ No _Yes: _____

REVIEW OF SYMPTOMS: please circle any current problems you have on the list below:

Constitutional
Fatigue
Fevers/chills/sweats
Unexplained weight loss/gain
Change in energy/weakness
Excessive thirst or urination

Eyes
Change in vision
Pain around eyes/ itchy eyes

Ears/Nose/Throat/Mouth
Problems with teeth/gums
Cold sensitivity in gums
Hay fever/allergies
Difficult hearing/ringing in ears

Respiratory/ ENT
Sinusitis / post-nasal drip
Cough/wheeze
Difficulty breathing

Psychiatric / Mind
Anxiety/Stress
Depression
Problem with sleep
Anger/ Rage

Cardiovascular
Palpitations
Chest pain/discomfort
Tendency to bruise/ Edema

Gastrointestinal
Bloating / Gas Pain
Acid reflux / heartburn
Abdominal pain / mouth sores
Blood in stool / diarrhea
Nausea/vomiting/ Indigestion

Genitourinary
Nighttime urination / bedwetting
Leaking urine / incontinence
Unusual vaginal bleeding
Discharge: penis or vagina
Problems with sexual function
Breast lump/nipple discharge
Ulcers/ Skin sores/ chronic itching
Chronic bladder infections

Neurological
Headaches / Migraines
Numbness
Dizziness/light-headedness
Memory loss
Loss of coordination

Blood/Lymphatic
Unexplained lumps
Easy bruising/bleeding

Musculo-skeletal & Skin
Back pain / neck pain
Muscle/joint pain
Rash/mole change
Arthritis

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CONSENT FOR PARTICIPATION
HOLISTIC HEALTH COUNSELING & TREATMENT

INFORMED CONSENT / LEGAL WAIVER:
In this time of increasing patient choices, **Good Medicine Works.** asks you to review the following statements and to provide a signature to confirm your agreement:

1. I am voluntarily consulting Dr. Bhaswati Bhattacharya, a board-certified preventive medicine, holistic licensed physician in New York, from my personal interest in my own health and desire to improve my self-care. I understand that I am taking personal responsibility for my health and what I do with my body.

2. I understand that Dr. Bhattacharya is teaching and leading this personalized program for me in the capacity of a trained holistic educator, certified holistic health counselor, holistic health expert, and scientist with specialty training in Ayurveda, alongside formal training, practice and medical license of a physician.

3. I understand that Dr. Bhattacharya is not serving as my primary-care physician (PCP), and I understand that I will consult my primary care physician for all emergencies and urgent care, not holding Dr. Bhattacharya liable for any urgent medical care or emergencies. I acknowledge that I am not deferring necessary medical care.

4. I have chosen to work with Dr. Bhattacharya voluntarily. I understand that the information I receive is a combination of conventional medical advice and standard medical thought, biomedical science, evidence-based medicine, preventive medicine recommendations, holistic medicine, health counseling, and lifestyle coaching. This combination of approaches is tailored for my overall well-being and is certainly not meant to take the place of seeing appropriate licensed specialists and health professionals.

5. I agree to communications with Dr. Bhattacharya via electronic mail (e-mail), text messages on my cellular phone, and understand that all communication is confidential between us, unless I given permission otherwise.

6. I take full responsibility for my health and for all decisions I make during and following this program, utilizing the knowledge I am given for my personal health.

7. I hereby release and discharge Dr. Bhattacharya from any and all claims that I or my family or anyone may have now, or in the future. I have read and understood all of the above, am fluent/conversational in English, and agree to proceed under these conditions.

8. I understand that the above is meant to have legal significance.

.....	Bhaswati Bhattacharya, MD
name - please print	Good Medicine Works.
.....	.....
signature	signature
.....	.....
date	date