Sanjevani Health and Lifestyle Center
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PATIENT HISTORY

PART ONE: GENERAL INFORMATION

First Name___________________ Last Name___________________ Date of Birth ___________

Preferred name, if different from above ___________________ Occupation___________________

Marital status: (check)
Single______ Married______Partner:_______Divorced______Widow_______ Race___________________ Age_______

Why are you here today? Routine Exam/Other ___________________

Family/Internal Medicine Physician ___________________Phone Number:___________________

Date Last Seen _____________ Are they supportive of you using natural and dietary changes? (Circle) Yes or No

Specialist Physician (i.e. Cardiologist, Neurologist, etc):___________________Phone Number:___________
Date Last Seen:_____________ Are they supportive of you using natural and dietary changes? (Circle) Yes or No

Have you had any of the following tests preformed within the last 5 Years? Circle all that apply:

Chemistry Profile/ Thyroid Testing/ Barium Enema/ Mammogram/ Cholesterol Screening/ Cholesterol Screening/HIV (AIDS)/

Sigmoidoscopy/ Colonoscopy/ Pap Smear/ Lipid Profile/ Stool Blood Test/ EKG/Blood Count/NutraEval/CDSA/Allergy Testing

Other Tests Preformed ___________________

Abnormal Tests Results ___________________

PART TWO: GENERAL MEDICAL HISTORY

Please check any past or current medical problems for yourself or immediate blood relatives.
X=Yourself **M**=Mother **F**=Father **B**=Brother **S**=Sister Grandparents: Maternal=**MGM/MGF** Paternal= **PGM/PGF**

Disease/Disorder	You	Family	Disease/Disorder	You	Family
1. Allergies			18. Diabetes		
2. Allergies - Food			19. Diarrhea		
3. Alzheimer's			20. Drug/Alcohol Abuse		
4. Anemia			21. Fibromyalgia		
5. Anxiety			22. Gallbladder Disorders		
6. Arthritis			23. Glaucoma		
7. Asthma, Lung Disease			24. Hearing Problems		
8. Autoimmune Diseases (circle) MS, Lupus, Rheumatoid, Celiac			25. Heart Disease/High Cholesterol		
9. Bladder Infections			26. Hemorrhoids		
10. Blood Clots			27. Hepatitis		
11. Blood Disorders			28. High Blood Pressure		
12. Breast Cancer			29. Insomnia		
13. Colon Cancer			30. Irritable Bowel Syndrome		
14. Constipation			31. Kidney Disease		
15. Chronic Fatigue			32. Lyme Disease		
16. Crohn's Disease/Ulcerative Colitis			33. Menopausal Symptoms		
17. Depression			34. Mental Illness		

35. Migraine Headaches			43. Reflux - Heartburn		
36. Obesity			44. Seizures		
37. Osteoporosis			45. Skin Diseases		
38. Other Cancers			46. Strokes		
39. Ovarian Cancer			47. Thyroid Disorders		
40. Pregnant or Nursing			48. Tuberculosis		
41. Prostate Enlargement			49. Ulcers		
42. Prostate Cancer			50. Other Illness:		

FAMILY MEDICAL HISTORY:

Please add date of birth, any illnesses past or present (including emotional-mental). If deceased, please list cause and age of death.

Mother: ___________________________ ____
Date of Birth Place of Birth

History ____

____

Father: ___________________________ ____
Date of Birth Place of Birth

History ____

____

PART THREE: ALLERGIES

1. Do you have any known **Medication ALLERGIES** (i.e. Penicillin, sulfa, etc.)? (Check) ____ Yes or ____No Known Drug Allergies

If yes, please list all known drug allergies:____

____

2. Do you have any known **Food ALLERGIES** (i.e. wheat, soy, corn, peanuts, etc)? (Circle) Yes or No

If yes, please list all known allergies:____

PART FOUR: PRESCRIPTION MEDICATIONS & OVER THE COUNTER MEDICATIONS

Please list **all** prescription medications you are currently taking including dose and times per day taking as well as what for that is being treated. To also including birth control, over the counter drugs (i.e. Tylenol, Advil, aspirin, etc.).

DRUG NAME	DOSAGE	FREQUENCY	WHY TAKING/TREATING CONDITION
Example: **Crestor**	**10 mg**	**1 per day**	**High Cholestal**
1.			
2.			
3.			
4.			
5.			

6.			
DRUG NAME	**DOSAGE**	**FREQUENCY**	**WHY TAKING/TREATING CONDITION**
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			

PART FIVE: NUTRITIONAL SUPPLEMENTS

Please list any vitamins, minerals, amino acids and other supplements you are currently taking

SUPPLEMENT NAME	MANUFACTURER	DOSAGE	FORM	FREQUENCY
Example: **Vitamin C**	**Twin Labs**	**500 mg**	**Capsules**	**1 Per Day**
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				

PART SIX: Please list all hospitalizations, surgeries, broken bones, and serious injuries below:

Year	Problem/Diagnosis	Operation	Comments
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

PART SEVEN: NUTRITION, WELLNESS & FITNESS

1. What is your blood type? ______________________________
2. What is your body type? (Circle all words that apply to describe yourself):
   slim, thin, wide, athletic, husky, petite, fat, muscular, average, medium, small, large, heavy-set.

3. What is your Ayurvedic Dosha? (i.e. Vata, Pita, Kalpha, Vata-Pitta, etc)? _______________ If you don't know check here ______

4. How would you describe your body's metabolism? (Circle one) very slow, slow, average, fast, very fast

5. What is your biggest meal of the day? (Circle) Breakfast, Lunch, Dinner

6. How do you feel after you eat? (Circle) light, energetic, heavy, tired, bloated, sleepy

7. How many ounces of water do you drink *daily*?
(Circle) None, <8 ounces, 8-16 ounces, 16-32 ounces, 32-48 ounces, 48-64 ounces, 64-80 ounces, 80-96 ounces, >96 ounces

8. How much refined sugar *daily* in teaspoons or grams? (1 teaspoon = 4 grams) May need to look up Nutrition Facts on package label of amount of sugar in grams you are eating?
(Circle) None, 4- 20 grams, 20-40 grams, 40-60 grams, 60-80 grams, 80-100 grams, 100-120 grams, 120-140 grams, 140-160 grams, 160-180 grams, 180-200 grams, >200 grams

9. How much fresh fruit do you eat *daily*? i.e. 1 serving = 1 cup fresh fruit or or ¼ cup dried fruit
   (Circle) None, 1 serving, 2 servings, 3 servings, 4 servings, 5 servings, 6 servings, 7 servings, 8 servings, 9 servings

10. How many fresh vegetables do you consume *daily*?
   (Circle) None, 1 serving, 2 servings, 3 servings, 4 servings, 5 servings, 6 servings, 7 servings, 8 servings, 9 servings

11. Do you currently smoke? (Circle) Yes or No
If Yes, how many cigarettes or packs of cigarettes a day? # cigs_____ #packs_________

12. Do you use recreational drugs such a marijuana? (Circle) Yes or No
If Yes, how much and how many times *per week*? ____

13. Do you drink alcohol? (Circle) Yes or No

14. If Yes, how what kind: (Circle one or more): Beer, Wine, Liquor

15. If Beer, how many beers *per week*? (Circle) None, 1-2 beers, 3-5 beer, 6-9 beers, >10 beers

16. If Wine, how many glasses *per week* (glass=5 ounces)? (Circle) None, 1-2 glasses, 3-5 glasses, 6-9 glasses, >10 glasses

17. If liquor, how many ounces *per week*? (Circle) None, 2-4 ounces, 4-8 ounces, 8-12 ounces, 12-16 ounces, > 16 ounces

18. Is drugs or alcohol a problem for you? (Circle) Yes or No

19. Do you drink Soda? (Circle) Yes or No Diet or regular? _________________
How many sodas *per week* (1 soda =12 ounces)? (Circle) None, 1-2 sodas, 3-5 sodas, 6-9 soda, >10 sodas

20. Other beverages?____

21. What enriched/refined starches do you eat *daily*? (Check all that apply): ______White Potatoes ______French Fries
_____White Rice _____White Pasta _____ Pastries/Donuts _____White Tortillas ______White Bread/rolls/bagels

22. How much fiber do you consume *daily* (i.e. in grams, teaspoons, cups, etc)? Grains ________________ Nuts _________________
Dried & Fresh Fruits ________________ Vegetables _________________ Seeds (flax, chia, hemp) _____________________

23. Do you eat canned foods? (Circle) Yes or No
If Yes, how many canned items *per week*? (Circle) None, 1-2 items, 3-4 items, 5-6 items, >7 items

24. Do you east microwaved foods? (Circle) Yes or No
If Yes, how many times *per week*? (Circle) None, 1-2 times, 3-4 times, 5-6 times, >7times

25. Do you read every food label? (Circle) Yes or No

26. How many times do you eat out *per week* (i.e. fast food, restaurants, etc)? (Circle) None, 1-2 times, 3-4 times, 5-6 times, >7times

27. Do you eat a lot of fast foods? (Circle) Yes or No
28. Do you eat a lot of junk foods (i.e chips, candy bars, cookies, ice cream)? (Circle) Yes or No

29. What are your eating weaknesses? ____

30. What are your eating strengths? ____

31. Do you have a good self-image? (Circle) Yes or No

32. How often do you exercise? (Circle) None, daily, weekly, monthly

33. Are you conscious of your breathing? (Circle) Yes or No

34. Do you know how to meditate? (Circle) Yes or No
If Yes, How often and for how long do you meditate? ____

35. Do you really love yourself? (Circle) Yes or No

36. Are you hard on yourself? (Circle) Yes or No

37. Do you reward yourself with bad foods? (Circle) Yes or No

38. Do you binge if you're sad or depressed? (Circle) Yes or No

39. Do you finish things you start? (Circle) Yes or No

40. Do you need other people's approval? (Circle) Yes or No

41. What foods make you happy? ____________________

42. Which food tastes do you crave? (Check all that apply) _____Sweet ______Sour _____Salty _____Bitter ______Spicy/Pungent _____Astringent

43. How often do you go to the bathroom daily? #1__________ #2____________
If you do not go daily, how often do you have a bowel movement?
(Circle) Every other day, Every 3 days, Every 4 days, Every 5 days, Every 6 days, Every 7 days, Greater than 7 days

44. Do you need a strict lifestyle program? (Circle) Yes or No
What is your favorite food type/cuisine? (List nationality and/or geographic region, i.e., Italian, Spanish, Mexican, Indian, Middle Eastern, Chinese, Thai, African)?

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NOTES/COMMENTS

Please share any additional information you believe would be helpful.

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PART EIGHT: MENTAL HEALTH HISTORY

1. Have you ever been sexually abused? (Circle) Yes or No

2. Have you ever been physically or emotionally abused by someone important to you? (Circle) Yes or No

3. Have you received counseling for abuse issues? (Circle) Yes or No

4. Have you had a recent major stress (i.e. loss of job, loss of loved one, change in marital status)? (Circle) Yes or No

PART NINE: GYNECOLOGICAL HISTORY

Section 1

1.1 Date of last Pap Smear ____________________ Have you had an abnormal Pap Smear? (Circle) Yes or No

If so, how was it treated____

1.2 Date of last Mammogram ____________________ Have you had an abnormal Mammogram? (Circle) Yes or No
If so, how was it treated?

1. 3 Date of last menstrual period? ____________________

1.4 Your age when you received your first menstrual period? _________

1.5 Do you have a menstrual period?(Circle) Yes or No If No, when did it stop? ______________________________

If Yes, How often do you menstruate? Every _________ to _______ days How long does it usually last? ___________

1.6 How heavy is your flow? (Check) Light ______ Regular ______ Heavy ______

1.7 Do you experience spotting or bleeding between periods? (Circle) Yes or No

1.8 Is menstrual cramping/pain a problem for you? (Circle) Yes or No

1.9 Is PMS a problem for you? (Circle) Yes or No

1.10 Are you presently using contraception (i.e. Pills, IUD, Tubal, Condoms)? (Circle) Yes or No

If yes, which type and brand? ____

1.11 Are you interested in a different type of birth control method? (Circle) Yes or No

Which type? ____

Section 2

2.1 Have you been sexually active within the last year? (Circle) Yes or No

2.2 If you are sexually active with whom? (Circle): men, women, both

2.3 Have you had a new sexual partner within the last year? (Circle) Yes or No

2.4 Do you experience pain with intercourse? (Circle) Yes or No

2.5 Do you experience bleeding with or after intercourse? (Circle) Yes or No

2.6 Do you have problems with incontinence (bladder/bowel control) during intercourse? (Circle) Yes or No

2.7 Do you any concerns about sexual activities? (Circle) Yes or No
If Yes, what are they?____

2.8 Have you ever been diagnosed with a female infection? (Circle) Yes or No

2.9 If yes, Circle all that apply: Trichomonas/ Gonorrhea/ Chlamydia/ Syphilis/ Chronic Yeast Infections/
Bacterial Vaginitis/ Vaginal Herpes/ Vaginal Warts/ HPV

2.10 Would you like to be tested for HIV/AIDS or other STDs? (Circle) Yes or No

2.11 Have you had any infertility problems or difficulty getting pregnant? (Circle) Yes or No

Section 3
3.1 Do you have any of the following Menopause or Perimenopause symptoms?

(Circle all that apply) Hot Flashes/ Vaginal Dryness/ Night Sweats/ Difficulty Sleeping

3.2 Are you using any non-medical treatments for the above symptoms? (Circle) Yes or No
If yes, what? ____

3.3 Are you using hormone replacement therapy? (Circle) Yes or No

3.4 Are you satisfied with this method? (Circle) Yes or No

3.5 Are you interested in alternative or natural therapies? (Circle) Yes or No

PART TEN: OBSTERTICAL HISTORY (Please indicate any miscarriages)

Month/ Year	Number of weeks at delivery	Baby's Sex	Baby's Weight	Describe any problems during pregnancy, labor or delivery	Vaginal/ Cesarean Birth?

List any elective/voluntary pregnancy terminations/abortions (AB)) or miscarriages (MIS):and circle type

1. Month/Year ________________Number of Weeks ________________(Circle) AB or MS
2. Month/Year ________________Number of Weeks ________________(Circle) AB or MS
3. Month/Year ________________ Number of Weeks ________________(Circle) AB or MS

PART ELEVEN: 5-DAY FOOD LOG

Please log everything you eat and drink over a five day period, including all liquids (particularly alcohol). If you are on a diet please specify which one, i.e.; Atkins, Paleo, South Beach, The Master Cleans, Vegan, etc.

(Please print clearly.)

Breakfast

Monday: ______________________________

Tuesday: ______________________________

Wednesday: ______________________________

Thursday: ______________________________

Friday: ______________________________

Morning Snack

Monday: ______________________________

Tuesday: ______________________________

Wednesday: ______________________________

Thursday: ______________________________

Friday: ______________________________

Lunch

Monday: ______________________________

Tuesday: ______________________________

Wednesday: ______________________________

Thursday: ______________________________

Friday: ______________________________

Afternoon Snack

Monday: ______________________________

Tuesday: ______________________________

Wednesday: ______________________________

Thursday: ______________________________

Friday: ______________________________

5-DAY FOOD LOG (Continued from previous page)

Dinner

Monday: ____

Tuesday: ____

Wednesday: ____

Thursday: ____

Friday: ____

Evening Snack

Monday: ____

Tuesday: ____

Wednesday: ____

Thursday: ____

Friday: ____

I HEREBY ACKNOWLEDGE THAT THE ABOVE INFORMATION IS CORRECT. I WILL NOT HOLD LIABLE AND HOLD HARMLESS Dr. Sunil Pai, MD, Maureen Sutton, LMT and all Sanjevani related companies, affiliates, agents and employees and Brigitte Britton, MegaWay/Cannabiseology companies, affiliates, agents and employees IN ANY WAY FOR ANY MEDICAL CONDITIONS BOTH EMOTIONAL AND PHYSICAL THAT MAY ARISE NOW OR IN THE FUTURE FROM THE USE OF ANY SUGGESSTED NUTRITIONAL PRODUCTS OR NUTRITIONAL/DIETARY PROGRAMS OR RECOMMENDATIONS. By signing this consent form I also agree to the Terms and Conditions of the Patient Consent Form that on file at Sanjevani Integrative Medicine Health & Lifestyle Center. Although clinical data and experience with use of recommended products have been established, since they are classified as "diet" and "dietary supplements", I understand that they are not approved or intended to treat, prevent or cure any disease according to the Food and Drug Administration. I AM ALSO REMINDED THAT I SHOULD CONSULT A DOCTOR BEFORE STARTING A NUTRITIONAL AND/OR EXERCISE PROGRAM.

CUSTOMER SIGNATURE: ____

TODAY'S DATE:_______/___________/____________