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The Nyerongsha Institute for Tibetan Medicine & Culture

TIBETAN MEDICAL CONSULTATION HEALTH HISTORY

(Please print clearly)

Today's Date: ____________

Name: ____________ **Date of Birth:** ____________

Street : ____________ **City:** ____________ **State:** ______ **Zip:** ______

Home Phone: ____________ **Work Phone:** ____________

Cell Phone: ____________ **E-Mail:** ____________

(CIRCLE ONE) **Male** **Female**

(CIRCLE ONE) **Single** **Married** **Widowed** **Divorced**

Please describe briefly:

1. Your general state of health / mind:

2. Major illnesses (include approx. dates)**:**

3. Serious injuries / operations / hospitalizations (include approx. dates)**:**

4. Special dietary practices:

5. Medications (including non-prescrip.)**:**

6. Exercise types / frequency:

7. Other health activities (e.g. massage, acupuncture, etc.)**:**

8. Spiritual / contemplative practice:

9. Visits with other Tibetan doctors (who, why, when, where)**:**

How often (and in what form) do you use the substances listed below?

	FREQUENTLY	SOMETIMES	RARELY	TYPE (e.g., cigarettes, ginseng, etc.)
Tobacco				
Recreational drugs				
Snack foods / refined sugar				
Nutritional/herbal supplements				

(continues on next page)

Please list any significant allergies / reactions *(medication, food, chemical, animal, environmental, etc.)*

SUBSTANCE	**REACTION**

Please briefly state age and state of health (or date/cause of death):

Parents:

Sisters / Brothers:

Children:

Please check any health issues that apply to you:

____ **Chronic fatigue/weakness**
____ **Unexplained fevers**
____ **Poor or excessive appetite**
____ **Recurrent bleeding**
____ **Sexual difficulties**
____ **Addictions**
____ **Sleep problems**
____ **Emotional stress**

Please check any physical area of health concern:

____ **Ears**
____ **Nose**
____ **Throat / mouth**
____ **Skin**
____ **Head**
____ **Lungs**
____ **Heart**
____ **Back**
____ **Intestines**
____ **Pelvic/urinary organs**
____ **Nervous system**

Other specific health issues or concerns:

WOMEN ONLY

Most recent period (day, month, year): **Typical length of cycle:**

Age periods began: **Approx. age periods ended (menopause):**

Number of births: **Number of miscarriages:** **Number of abortions:**

Describe any complications during pregnancies or births:

Sexually active? Yes No **Type(s) of contraception being used:**

Briefly describe your cycle (incl. problems such as heavy bleeding, PMS, severe cramping, etc.)**:**