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THE NYERONGSHA INSTITUTE FOR TIBETAN MEDICINE AND CULTURE

TIBETAN MEDICAL CONSULTATION HEALTH HISTORY

(Please print clearly)

Today's Date: _____

Name: _____

Date of Birth: _____

Street : _____

City: _____

State: _____

Zip: _____

Home Ph: _____

Work Ph: _____

Cell: _____

(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 FORM (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:

- | | | | |
|---|--------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Ears | <input type="checkbox"/> Skin | <input type="checkbox"/> Heart | <input type="checkbox"/> Pelvic/urinary organs |
| <input type="checkbox"/> Nose | <input type="checkbox"/> Head | <input type="checkbox"/> Back | <input type="checkbox"/> Nervous system |
| <input type="checkbox"/> Throat / mouth | <input type="checkbox"/> Lungs | <input type="checkbox"/> Intestines | |

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.):
