DOCTOR ELANGO AYUSH HOSPITAL

For (SPECIALLY DESIGNED INTEGRATED TRADITIONAL MEDICAL TREATMENTS)

Plot Number 140, VGP Selva Nagar Extension, Velachery, Chennai-600042.- INDIA

+91 78248 83355 / +91 89397 51815 www.DoctorElango.com

1. Full Name * _____

2. Date of Birth D D M M Y Y Y Y

3. Gender ◯ **Male** ◯ **Female** ◯ **Transgender**

4. Full Address _____

_____

_____

5. Email * _____

6. Mobile Number * _____

7. Place of Living * _____

8. Religion _____

9. Marital status ◯ **Married** ◯ **Unmarried**

10. Occupation * _____

11. Does your profession have day and night shift system? *

◯ **Day Shift** ◯ **Night Shift** ◯ **Day & Night Shift**

12. Personal History

a. Height [in cm] _____ **b) Weight [in Kg]** _____

c) Appetite _____ **d) Sleep** _____

e) Bowl Movement _____ **f) Urination** _____

13. Blood Pressure _____

14. Sugar Level _____

15. Enter Your Problems / Diseases in one by one with duration of suffering

1) Problem / Diseases - Duration _____

2) Problem / Diseases - Duration _____

3) Problem / Diseases - Duration _____

4) Problem / Diseases - Duration _____

5) Problem / Diseases - Duration _____

6) Problem / Diseases - Duration _____

7) Problem / Diseases - Duration _____

16. Menses Condition Details (in case of women) _____

17. Do you Suffer from any type of Hernia? _____

18. Have you suffered with heart ailment in the Past? (please give full detail)

_____

_____

19. Please tick your Habits:

☐ **Tea** ☐ **Coffe** ☐ **Smoking** ☐ **Taking Alcohol** ☐ **Drug Addiction**

Any Other Habits, Please Specify _____

20. Can you walk 1 Km without any Support? (If can't, give detail why?)

21. Details of the operations undergone (specify the year also)

22. What medicines you are taking at present for your ailments?

23. Your Food Habits?

◯ **Veg** ◯ **Non Veg** **Your favorite Foods ?**

24. Do you practice daily any kind of Yoga, Pranayama, Nadi Suthi or Physical exercises etc...?

◯ **Yes** ◯ **No**

25. Have you suffering from Diabetes Complaints, if so, please give the details.

26. Does your blood have HIV? *

◯ **No** ◯ **(IF YES please Send HIV Test report to contact@DoctorElango.com)**

27. Are you using any temporary contraceptive method while having sexual intercourse?

28. Have you masturbation habit earlier or now ? If yes, How many years ?

29. Are you suffering from any Psychological disorder?

30. Are you suffering from Extreme worries, Fears, Anxieties, Confusions, Severe Difficulties of life, Marital Life Problems or Friend ?

31. Have you personal problems of any nature which you hesitate to discuss with your life partner (or) family member (or) friend ? (if so, please give full details)

32. Are you wearing any Gems (or) Precious stones in any of your ornaments, for any medical value (or) for best lucks ? (if so, please give full details)

33.Have you infected by Covid-19?

◯ **No** ◯ **Yes**

34. Have Covid-19 vaccinated, please give details.

35. Do you want to inform us any more things?

36. Why do you prefer Our Natural Healing System ?

37. How did you know about the services and address of our Doctor Elango Ayush Hospital ?

Date :

Place :

Patient Signature or Left Thumb Impression

Signature of the Subbmitter

- For Office use Only - - - - - - - - - - - - - - - - - - -

Application Accepted / Rejected: **For the below Stated Reason**

Attending Doctors Name