

# Holypills clinics

**DR. ILA KATHURIA**

DHMS. BHMS



<b>Noida</b>		<b>Con. Place</b>		<b>South Ext. II</b>	
(Opposit GIP Mall)		(Near Matro Station)		(Near Market)	
<b>UGF-4, Ocean Complex Sector - 18</b>		<b>4 - S, DCM Bulding Barakhamba Road</b>		<b>C - 35 South Extn. - 2</b>	
<b>Days &amp; Time</b>		<b>Days &amp; Time</b>		<b>Days &amp; Time</b>	
Tuesday & Thursday	10:30 AM To 01.30 PM	Monday Wednesday Friday	11:30 AM To 2.00 PM	Tuesday & Thursday	5:30 PM To 8.00 PM
Monday Wednesday Friday	05:30 PM To 08.30 PM				

**STURDAY CLOSED**

Email : drkathuria@hotmail.com

## (Patient Questionnaire)

The kind of medicine we practice requires extensive background information. To help us understand how to aid you most fully in regaining your health, we ask that you fill out our patient questionnaire. The information you provide helps us to personally understand your needs and begin designing a specialized treatment program for you. please keep in mind that absolute confidentiality is assured in this matter.

Date

NAME

SURNAME

FATHER'S / MOTHER'S NAME

AGE

SEX

PRESENT WT. & HT.

NATIONALITY

MARITAL STATUS

PROFESSION / OCCUPATION

ADDRESS

TELEPHONE/S  
FAX NO.

**EMAIL ADDRESS**

**PRESENT COMPLAINTS (MAIN COMPLAINTS):**

- 1.
- 2.
- 3.
- 4.
- 5.

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**ONSET  
ORIGIN OR CAUSE OF EACH COMPLAINT:**

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**PAST HISTORY (PREVIOUS DISEASES AND THEIR TREATMENT)**

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**FAMILY HISTORY (Give in detail if any of your blood-relatives i.e. parents, grandparents, siblings, aunts and uncles are suffering or have suffered from the following ):**

**Allergies:**

- Eczema** \_\_\_\_\_
- Hay fever** \_\_\_\_\_
- Sinusitis, Cold** \_\_\_\_\_
- Allergic bronchitis** \_\_\_\_\_
- Asthma** \_\_\_\_\_
- Urticaria** \_\_\_\_\_

**Arthritis:**

- Gout** \_\_\_\_\_
- Osteo-arthritis** \_\_\_\_\_

Rheumatoid arthritis \_\_\_\_\_

Cancer / Malignancy \_\_\_\_\_

Diabetes Mellitus \_\_\_\_\_

Hypertension \_\_\_\_\_

Coronary Artery Disease, Angina etc. \_\_\_\_\_

Tuberculosis \_\_\_\_\_

Gonorrhoea / Syphilis or STD \_\_\_\_\_

Psychiatric & Mental Disorders \_\_\_\_\_

Schizophrenia \_\_\_\_\_

Anxiety Neurosis / Depression \_\_\_\_\_

Any other sickness not mentioned above? \_\_\_\_\_

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**PERSONAL HISTORY**

Kindly elaborate and mention habits, addictions like alcohol, smoking, tobacco etc.

**Appetite :**

Are you vegetarian or non-vegetarian? **Veg / Non-Veg**

Do you take eggs? **Yes / No**

**Cravings in food:**

Mention grades of preference + , ++ or +++.

For example if you love sweets, mention + or ++ or +++

Sweets

Salty food

Do you add Extra salt in your food?

Sour things / pickles

Seasoned and spicy

Milk

Eggs

Fried and fats

Any other cravings in food?

Do you dislike sweets or salty or any other specific food?

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**How is your Digestion?**

Any complaints after eating? For example... Yes / No

Fullness of abdomen, Gas formation or Diarrhoea after eating  
Do you feel bloated, full and heavy after eating? Yes / No

Can you remain hungry for hours on end without food?  
Do you get irritable with hunger? Yes / No

Does any item of food causes any discomfort eg. Acidity, headache,  
flatulance etc. Yes / No

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**Thirst:**

How is your thirst? Please mention the grade of thirst? If you are very thirsty, you may mention grades + , ++ or +++

How much water do you take at a time?

How many times per day?

Your preference in drinks: Please mention the degree of craving +, ++ or +++

Would you prefer cold / chilled water or drinks even in the height of winter? Yes / No

Would you like your cup of tea or coffee piping hot? Or just normal warm?

How many cups of tea / coffee do you generally take in a day?

Any aversion to any drinks?

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**GENERALITIES**

State how you are affected by or how you react to the following:

1. Cold in general, cold air, drafts, cold winds etc.
2. Do you like to cover your head (or wear a cap) when you go out in the cold or when exposed to draft of cold air?
3. Warmth in general, warmth of bed or of room, external warmth like hot fomentation etc.

4. Weather: Dry, Cold wet, Rains, Cloudy etc.
5. Thunderstorms
6. Open fresh air
7. Near the sea / on mountains
8. Eating and Drinking (before, during and after)
9. Fasting
10. Any particular item of food / drinks which adversely affect you or make you sick
11. Closed, Crowded places, Elevators / Lifts etc.
12. Exertion or Physical strain, Mental strain
13. Lack of sleep
14. In what part of 24 hours do you feel the best or the worst?
15. Do your troubles tend to occur or become worse, periodically (eg. Daily or alternate days, every week, yearly, during new or full moon etc.)

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#### **STOOL / BOWEL MOVEMENTS**

Do you regularly have a satisfactory bowel evacuation? Yes / No

How many times do you move the bowels? When?

Consistency: whether  Well formed  Semi-formed  Very hard  Loose?

Odour

Colour of stool

Any straining required or stool even though stool might not be hard or constipated? Yes / No

Any urgency for stools (eg. Do you have to run for stool first

thing in the morning or immediately after eating?

**Any pain, burning, bleeding with stool?**

**Piles / Fissure / Fistula?**

**Do you have flatus (wind) when passing stool and is the stool noisy and spluttering?**

## **URINE**

**Frequency, day and night**

**Any burning during urination?**

**Any smell (Odour) in the urine?**

**Any difficulty in passage of urine?**

**Any difficulty in retaining urine? Do you have any incontinence while coughing or sneezing? Is the urine very urgent and you must rush immediately or it will escape?**

**Any associated complaints with urination?**

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## **SEXUAL SPHERE**

**FOR MEN – Any sexual disturbance?**

**Excessive desire or aversion to sex**

**Disability of performance, premature ejaculation etc.**

**Night emissions**

**Any history of sexual abuse, excessive masturbation etc.**

**Any complaints after intercourse?**

**FOR WOMEN – Any sexual disturbance?**

**Desire / Aversion to coitus?**

**Any leucorrhoeal discharge? Itching, burning or discomfort associated?**

**Any sense of 'bearing down' at the time of menses?**

**PREGNANCIES : How many times have you been pregnant?**

**How many children do you have and their age?**

**Did you have smooth pregnancies?**

**Did you take any medication during pregnancy?**

**Did you have normal deliveries?**

**MENSES: Age of appearance of first period (Menarche)**

**How are the periods? – (regular or irregular)**

**What is the duration of your period and how many days cycle?**

**How is the flow? – (scanty, heavy, clotted, any odour, colour)**

**Any PMT (Pre-menstrual tension)? Do you have any complaints associated with, before or after menses? Eg. Moods, Headache, irritability, Anger, Weeping, Depression, Diarrhoea or Constipation**

**Any changes in your skin around menses?**

**Any heaviness or pain in breasts before menses? Any nodules in the breast?**

#### **MENOPAUSE:**

**Age of menopause**

**Any associated complaints at the time of menopause eg. Hot flushes, Palpitation, Anxiety, Depression etc.**

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#### **PERSPIRATION (SWEAT):**

**Do you perspire a lot?**

**Any particular part of the body that you perspire more on?**

**Any strong / offensive odour associated (eg. Sour smell) with the sweat?**

**Does the perspiration stain the clothes?**

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#### **SLEEP:**

**Do you sleep well?**

**Any particular posture in which you lie the most when you sleep? eg. Lying on the sides (right or left), back or on your abdomen, curled up etc.**

**Do you feel refreshed after sleep?**

**Do you dream while sleeping?**

**Any particular dream that is recalled and often repeated? (eg. Frightening dreams of falling from a height, or being pursued by some men, or dead people or relatives etc.)**

**Does any of your complaints get worse or better before, during or after sleep? eg. Cough or asthma attack that wakes you up at night or migraine on waking in the morning. Hot flushes just as you begin to fall asleep.**

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#### **SKIN:**

**Any skin problems that you have or had earlier? (eg. Allergies, eczema, fungal infections, pigmentations, acne etc.)**

**Any itching or discoloration associated with it?**

**Any factors which worsen the skin problem? eg. Any item in food, any weather conditions or washing with warm or cold water.**

**Any treatment taken for it and its details?**

**Any complaints or abnormality of Nails or the skin around nails?**

**Any complaints of Hair falling, early greying, dandruff, thinning etc.?**

**Any warts, moles, birth marks on the body?**

**Does your skin heal normally after an injury or takes very long to heal?**

**Any tendency to form excessive scar tissue (Keloids)?**

**Any tendency for wounds to suppurate (form pus easily)?**

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### **THE MIND:**

**(It is very important to give as much details as possible in this section of the Proforma especially in Chronic diseases)**

**Have you noticed any marked changes in your mental state lately? If so, describe it in detail please.**

**Have you become or are-**

- 1. Anxious / afraid of anything eg. Being alone, animals, darkness, disease, thieves, robbers, sudden noises**
- 2. Do you get startled easily by sudden noises, telephone bells, banging of doors etc.**
- 3. Suspicious, doubting**
- 4. Impatient or hurried and hasty  
Do you eat hurriedly and there is always a sense of hurry?**
- 5. Offended easily (cannot take any criticism)**
- 6. Are you critical of others, always finding faults**
- 7. Irritable, quarrelsome, violent etc.**
- 8. Depressed easily, sad, gloomy**
- 9. Timid / Shy / Bashful**
- 10. Jealous or Suspicious**
- 11. Anxious, restless, nervous or excitable**
- 12. Do you feel very anxious and apprehensive before examination, before stressful situations, public engagements etc.?**

13. Are you silent, quiet, reserved or talkative?  
Do you make friends easily?
14. Are you very affectionate? Do you demand love and warmth from others?
15. Do you cry easily?  
What makes you cry (grief of others, music kind words of affection etc.)
15. Are you very sympathetic in general and go out of your way to help people in need?  
Are you easily moved to tears at the plight of others?
16. If someone consoles you when you are upset, does it help or does sympathy towards you makes the matters worse?
17. How do stand and react to contradictions?
18. Are you an authorotative person, always in command and giving orders and expecting them to be followed by everyone around you?
19. Any imaginary fears or feelings? (eg. That someone might want to harm you or hurt you and that people are against you)
20. How is your memory, power of concentration and mental ability?
21. Do you feel humiliated or hurt easily? Would this give rise to any physical complaints?
22. Are you over conscientious about details, cleanliness, tidiness, punctuality etc.?  
Are you a perfectionist by nature, being meticulous, fastidious and even finicky?
23. What is the greatest grief that you have felt in life? Also what are the greatest joys in life you have experienced?
24. Can you mentally relax easily? For instance, can you switch your mind off work, problems, children etc.? Do you enjoy vacations? And can you totally relax when on a holiday or do thoughts of work or what is happening at home keeps bothering you etc.
25. At work or with colleagues, subordinates or your boss or seniors how do you equate with them? Would reprimand or scolding from them upset you tremendously? If so how?

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### PREVIOUS TREATMENT TAKEN

Disease	Medicine Prescribed	System of Therapeutics
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### INVESTIGATIONS

#### LABORATORY TESTS

X-RAY, SCANS, MRI etc. others

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