

**Patient Registration Form**

Patient Status: IP / OP Time:

Nationality: NRI / Foreigner / Indian Date:

Name: Mr / Mrs / Miss / Ms. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: Male / Female Age: \_\_\_\_\_Wt: \_\_\_\_\_

Marital Status : Married / Unmarried / Widowed / Separated

Father's / Husband's Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Religion : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Educational Qualification/

Profession : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Residential Address : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_Country:\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact No. Res: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Off : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Complaints / Diseases : 1. 5.

2. 6.

3. 7.

4. 8.

Surgeries undergone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you suffer from any psychological illness? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes please mention the condition and medications taken. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal history:**

1. I am a - Pure vegetarian / Mixed / Ova vegetarian / Lacto vegetarian

2. My digestion is - Normal / sluggish / quick

1. My bowels are - regular / regular but unsatisfactory / constipated / many times and frequent
2. I have a - strong appetite / No appetite / perverted appetite
3. I Snack - mildly / moderately / heavily and often
4. I am addicted to - Tea / coffee / pickles / sweets / hot and spicy foods / eating in restaurants
5. I consume - alcohol / cigarettes / pan/ tobacco / others / Nothing
6. I practice - Exercise / yoga / Walking / Gym / taichi / Nothing

How do you know about the

hospital? : Advertisement / Board / Friend / Old Patient / Others

Referral details if any : Doctors / Old Patient / Management / Others

Name of the Referral :

Purpose of Admission : Treatment of body ailments / Rejuvenation

Have You Been Treated in

our hospital Earlier : YES NO

If Yes How many times and :

for what purpose

Accommodation Preferred : Single / Sharing

Type of Accommodation : Temple room-A/c Non A/c Valley Room- A/c Non A/c

Cottage A/c Family cottage A /c Dormitory room

Your weight on discharge during the last visit : \_\_\_\_\_\_\_\_\_\_\_ kgs

Person to contact in case of emergency: Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact No: 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship with the patient : Parent / Brother / Sister / Wife / Husband / Friend

Date: Patient Signature