Ayurvedic Herbal Clinic and Spine Pain Management Centre Croydon UK.

Dr Avtar Singh PG.UK (AYURVEDA RATNA) 07956640643 Consultation with appointment only.

575 Purley way Croydon cr04rj UK www.ayurvedicherbalcentre.com

{COVID [WISHAM JWARA] CHECKLIST (As per my experience) I have treated many patients who all had different symptoms that is why I have made this checklist.

Name -- .... Variant ....

D>O>B.. PHONE/NO...

FEVER reading	Mild 98.5F --	
Sneezing	Mild	Severe
Running nose	Mild	Severe
Breathing difficulty you can easily Hold breath for up to10sec	Breathless while Mild You climbing steps	Moderate \ Severe
Body Pain	Mild	Severe
Sore Throat Cough	Moderate	Severe
Tongue- colour loss of taste		
Weakness Fatigue	Moderate	Severe
Constipation Diarrhoea	Episodes in last 24 hours	Last 48 hours
Appetite	Normal	Low V-Low
How often do you pass urine and what is the colour		
Headache	Mild	Severe
Cough Dry How long	Mild	Severe
Mucous Colour	Any blood	
Travel History	Any Contact with Covid-19	

If you have more than three any of the above signs please be alert and contact your Doctor.

Please keep well and stay safe and follow the instructions given by the Government

Any other Symptoms please mention.

SIGN.. DATE...

Dr Avtar Singh. Ayurveda Ratna [PG] College of Ayurveda (UK)
Ayurvedic Herbal Clinic and Spine Pain Management Centre

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Patient's Health Questionnaire

First name: .... Surname/s ....
Date of birth: .... Sex: male [ ] female [ ] Weight ....
Address: ....
Mobile Number: .... Occupation: ....
Email ....

Medical History

Do you suffer or have suffered from any of the following conditions, if yes since when?

Heart Disease	Yes [ ] No [ ]	Since:
Stroke	Yes [ ] No [ ]	Since:
Cancer	Yes [ ] No [ ]	Since:
Diabetes	Yes [ ] No [ ]	Since:
Asthma	Yes [ ] No [ ]	Since:
High or low blood pressure	Yes [ ] No [ ]	Since:
Kidney problems	Yes [ ] No [ ]	Since:
High Cholesterol	Yes [ ] No [ ]	Since:

Please list any other serious **illness, operations or accidents** you had in the past (give details if possible).

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Please list any **medicines/tablets** you are currently taking or if you have taken in the past.

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Do you have any **allergies?** Yes [ ] No [ ] Smoker [ ] Non – smoker [ ]
Please list any allergies

....

....

Please circle your option and sign to confirm.
Summery care record______________ I consent ( )
Care data and sharing data model.___ I consent ( )
I________________________________ The under signed the Res=of___________________________________

I hereby authorise Dr Avtar Singh to perform Ayurvedic treatment on me and I further authorize him to carry on additional or alternative treatment\measures as in his opinion may be found advisable. The nature of the said treatments has been fully explained to me in detail. This is further to confirm that the doctor shall not be responsible for any accident arising.

Signature/patient or behalf of patient____Date_______________

REFFERD BY DR...Date..