East/West Integrated Medicine
Nita Desai, M.D.
333 So. Boulder Road Suite 1
Louisville, CO 80027
(303) 444-1999
www.nitadesaimd.com

Directions to office:

- Map & Directions to Dr. Desai's office
  - From Denver and points east along Route 36 West toward Boulder
    - Take Baseline exit
    - Go straight through light to frontage road
    - Take a right on Aurora Avenue
    - Take a left into parking lot at 2885 Aurora Avenue
  - From Boulder
    - Take Baseline Road East
    - Turn left onto 30th Street
    - Take the second left at the light on Aurora Avenue
    - Take a right into parking lot at 2885 Aurora Avenue
  - See or print a map on MapQuest®

Recommended books on Ayurveda you may want to read before your appointment:

- *Perfect Health* by Deepak Chopra
- *Ayurvedic Cooking for Self Healing* by Usha Lad & Dr. Vasant Lad
- *EAT•TASTE•HEAL: An Ayurvedic Cookbook for Modern Living* by Thomas Yarema, MD; Daniel Rhoda; and Chef Johnny Brannigan

Instructions from Dr. Desai for new patients:

- Please come 5-10 minutes early to your new appointment.
- Please bring in all supplements, herbs or vitamins you are taking as the doctor needs to see the bottles.
- Please bring in all medication bottles
- Please bring in or mail two weeks before your visit any blood tests you have had in the last five to ten years. Dr. Desai often disagrees with what other doctors may consider normal.
- If you have any other testing (ex. ultrasound reports, etc.) relevant to your condition, bring in those reports. Dr. Desai does not need all your medical records.
- No fingernail polish at first visit.
- Mail your patient information form and history form to us two weeks before your appointment date.

Patient History

RUGNA PATRAKAM

Date_____

Please complete this form and mail in to our office two weeks before your first appointment. Our address is 2885 Aurora Avenue Unit #23 Boulder, CO 80303.

Name	
Age	
Gender	
Phone (best # to leave a message)	
Birthdate	
Birth place	
Marital Status	
Occupation	

Please explain your chief concerns:
(Please give date of onset of each condition, progression, aggravating factors, any treatment you have tried and results of such treatments. List each condition in chronological order or on a separate page if necessary.)

Past Medical History

1.Any illness, hospitalization, injury, accident, or surgery as a child?

Problem	Date(s)	Treatment	Resolved/still an issue

2. Any illness, hospitalization, injury, accident, or surgery as an adult?

Problem	Date(s)	Treatment	Resolved/still an issue

3. Date of last lab testing:_____
Any abnormal findings?_____

Date of last complete physical:_____ Any abnormal findings?_____

Emotional Traumas

Have you had any significant emotional traumas? (ex: death, divorce, history of abuse, difficult childhood)

Have you been treated for any mental/emotional illness?

Medications/ Supplements

What medications are you currently taking?

Name	Dose	For what condition

What supplements are you currently taking?

Name	Brand Name	Dose	Reason for taking

Allergies

Do you have any allergies or intolerances to the following?

Medications	
Foods	
Environmental substances, pollen, or chemicals	
Do you have Hay Fever or seasonal allergies?	

Family History

Please list your family members current age and any medical conditions they have

Mother	
Father	
Siblings	
Are there any conditions that run in your extended family?	

Habits/ Addictions

	Yes	No	If "Yes":
Do you drink coffee?			# cups/day
Do you drink black tea, green tea, or matte?			# cups/day
Do you drink soda?			# cans/day
Do you eat chocolate?			Amount eaten daily
Do you have any other source of caffeine?			
Do you drink alcohol?			What kind? How much? How often?
Have you ever had an alcohol addiction?			
Do you smoke tobacco?			How much?
Have you ever smoked tobacco?			How much? When quit?
Do you frequently use over the counter medication?			Name? For what reason?
Do you use any illegal drugs/ substances?			
Do you consume white flour and/ or white sugar?			
Is there anything that you feel is a habit or addiction in your life?			Please explain:

Cravings

Do you have any food or taste cravings?

Digestion

How is your digestion?

Are you hungry in the morning?

After your first meal of the day is your appetite regular and predictable 2-3x a day or is it irregular and variable each day?

Do you have a problem with frequent gas, bloating heartburn, burping, belching, or any abdominal discomfort or pain?

Do you get lightheaded, irritable, low energy, or cannot function well if you skip a meal?

Do you often skip or forget to eat meals? Please note the number of meals eaten per day.

Do you eat frequent small meals? How many?

Elimination

Do you have a bowel movement daily?
times/day

Do you have a tendency toward constipation or diarrhea?

Any problems with urination?

Menstruation (*for Women only*)

Do you have regular menstrual periods?	
# days of cycle	
# days of bleeding	
Is the bleeding heavy?	
Any PMS symptoms?	
Cramping?	
Before or after bleeding starts?	
Any pregnancies?	
Any difficulties with pregnancy?	
How many children do you have?	
List ages and any health concerns.	
Are you in menopause?	
Any symptoms?	

Heat/ Cold

Are you frequently cold when others seem comfortable?

Are you frequently warm when others seem comfortable?

Do you prefer warm or cold weather?

Sleep

Do you sleep well?

Time you go to bed

Time you wake up

Do you feel awake and ready to go in the morning?

Please describe any sleep disturbances:

Energy

Describe your energy level

Any drops in energy through the day?

Exercise

Do you exercise regularly? # times per week and what type

Emotions

Do you have any emotional issues at this time?

How do you react when under stress?

Are you a frequent worrier or anxious and fearful?

Are you frequently angry or irritable?

Do you tend to get depressed or sad easily?

Daily Routine

What is your daily routine from waking up in the morning to going to bed at night?

Diet

What time do you usually eat **breakfast**?	AM/PM
What do you usually eat?	
What time do you usually eat **lunch**?	AM/PM
What do you usually eat?	
What time do you usually eat **dinner**?	AM/PM
What do you usually eat?	
What time do you usually eat **snacks in the morning**?	
What do you usually eat?	
What time do you usually eat **snacks in the afternoon?**	
What do you usually eat?	
What time do you usually eat **snacks before bed?**	
What do you usually eat?	
What do you usually drink (tea, juice, soda, etc.)?	
How much do you usually drink?	
How much water do you drink on a typical day?	
What other foods do you eat regularly (weekly)?	

Please keep a three day food diary and send it in with this history.

Patient Information Sheet

Instructions: Please fill out completely and mail to the above address. Information must arrive at least 2 weeks before your appointment.

Patient's Full Name	
Age	
Gender	
Address	
City	
State & Zip	
Phone (day & cell)	
Phone (evening)	
Email	
Birth date	
Referred by	
Date of First Visit	
Onset of illness date	

Insurance information for our files:

Insured's Name	
Birth date	
Insured's Address	
Phone	
City	
State & ZIP	
SSN	
Patient's relationship to the insured	
Insurance Company's Name	
Customer Service Telephone Number	

I authorize the release of any medical or other information necessary to process any claim I submit. I also request payment of government or private benefits to myself or to the party who accepts assignment to this claim.

_____ _____
SIGNATURE OF RESPONSIBLE PARTY Date

I agree to pay for all services at the time they are rendered. I agree to pay for any appointment cancelled with less than 48 hours notice.

_____ _____
Signature Date

Credit Card Number: _____

Vcode: _____ Expiration Date: _____

(This information is kept on file in case of payment issues and will not be used unless you are delinquent in payment.)

In case of emergency or need for hospitalization:

Primary Care Physician Name: _____ Phone:_____