**SWASTHYA BHANDAR**

**MEDICAL HISTORY OF THE PATIENT**

**Directions for filling the form:**

1. Complete the Microsoft Word form by downloading it from **Swasthya Bhandar’s** website. Complete the Form on your *Personal Computer/ Tablet/ Mobile Phone* and send the completed Form through ***Email*** to drds@swasthyabhandar.com or drds1947@gmail.com
2. To find out a correct Remedy and allied course of treatment, a lot of information about the (i) Complaints – (a) Main and (b) Subsidiary – and (ii) the patient as a Person is required.
3. Incomplete information will make it difficult to find correct treatment or even result in inaccurate treatment. Therefore, please provide complete information without holding back anything considered irrelevant or unimportant. The information you provide forms the basis for further enquiry and will enable us to assist you in further delineating the problem.  Full cooperation, therefore, is desirable. All information provided is kept strictly confidential; only the concerned doctor will read the information for diagnosis.
4. While hiding any fact, whether willfully or ignorantly, may result in inadequate or incorrect selection of remedy and allied treatment, incomplete information may raise further queries and time-wasting correspondence and delay in starting the treatment. We, therefore, solicit your full co-operation in providing as much detailed information as possible in the first instance itself.

**DECLARATIONS**

**(Please carefully read the declaration. Put an “X” Mark in All of the Following; otherwise, the Doctor will not be able to proceed with the treatment.)**

[ ]  **I confirm that the information provided is complete and accurate to the best of my knowledge.**

[ ]  **I hereby give my consent to the doctor to use all the information to decide my treatment.**

[ ]  **I confirm that I have read and understood the therapies used and the case study.**

1. **PRELIMINARY INFORMATION**

|  |  |
| --- | --- |
| Name of the Patient (in full) | Click or tap here to enter text. |
| Name of the Guardian (In case patient is a minor) | Click or tap here to enter text. |
| Complete Address (Flat/House No., Block No., Name of the House/ Apartment, & Street No. and Name, Locality, and Landmark | Click or tap here to enter text. |
| City | Click or tap here to enter text. |
| Sate | Click or tap here to enter text. |
| Pin code/Zip code | Click or tap here to enter text. |
| Email ID | Click or tap here to enter text. |
| Alternate Email ID | Click or tap here to enter text. |
| Phone No./ Mobile No. (with Country Code) | Click or tap here to enter text. |
| Alternate Phone No./ Mobile No. (with Country Code) | Click or tap here to enter text. |

1. **DEMOGRAPHIC INFORMATION**

|  |  |
| --- | --- |
| Date of birth (in mm/dd/yyyy format) | Click or tap here to enter text. |
| Age (in years and or months) | Click or tap here to enter text. |
| Gender | Choose an item. |
| Marital Status | Choose an item. |
| If Married, number of Children | Choose an item. |
| If Divorced, Since When (in years and or months) | Click or tap here to enter text. |
| Occupation (Current and previous with the level of job satisfaction achieved. Does the job require travelling? If yes, what is its frequency?) | Click or tap here to enter text. |
| Description of the patient's current family set-up (Full details about all the family members: their age, location, work they are doing, and their relationship with the patient; also, responsibilities for them. Include those who have expired, stating the age of death, the year and the cause of the same) | Click or tap here to enter text. |
| The patient's daily routine, from getting up in the morning to retiring at night, gives a complete account. | Click or tap here to enter text. |

1. **PATIENT’S CURRENT COMPLAINTS**

|  |  |  |
| --- | --- | --- |
| **Serial No.** | **DESCRIPTION** | **DURATION**  |
| 1 | Click or tap here to enter text. | Click or tap here to enter text. |
| 2 | Click or tap here to enter text. | Click or tap here to enter text. |
| 3 | Click or tap here to enter text. | Click or tap here to enter text. |
| 4 | Click or tap here to enter text. | Click or tap here to enter text. |
| 5 | Click or tap here to enter text. | Click or tap here to enter text. |
| 6 | Click or tap here to enter text. | Click or tap here to enter text. |

|  |  |
| --- | --- |
| Complete history of present complaints (Please see the directions below) \* | Click or tap here to enter text. |
| Complete details of investigations done so far | Click or tap here to enter text. |
| Details of ongoing treatments or those done in the past and the patient's response to those treatments | Click or tap here to enter text. |
| Current Medication | Click or tap here to enter text. |
| Known allergies (if Any) | Click or tap here to enter text. |
| History of previous illnesses(Major ones only) | Click or tap here to enter text. |

\*Directions for mentioning present complaints:

This should give a whole idea of:

* Area affected: location, extension, direction of spread, the march of events.
* Sensation experienced in the area of trouble.
* Conditions that have brought on the trouble: examine the circumstance that occurred just before or at the time of onset, paying attention to physical as well as emotional factors.
* Conditions that increase the trouble or those that give relief.
* Other troubles that the patient experiences along with the central trouble, for example, perspiration/nausea/vomiting/gas, etc., along withpains.

**Other Complaints (Irrespective of having any correlation with major complaints)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Serial No.** | **Description** | **Duration** | **Treatment & present status** |
| 1 | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| 2 | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| 3 | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| 4 | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| 5 | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| 6 | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

1. **OTHER PHYSIOLOGICAL INFORMATION**

**State of Digestion**

|  |  |
| --- | --- |
| Appetite | Choose an item. |
| Bowel HabitsHow many times during the day and night? | Choose an item.Click or tap here to enter text. |
| Urine QuantityHow many times during the day and night? | Choose an item.Click or tap here to enter text. |
| Sleep | Choose an item. |

**Menstruation (if Applicable)**

|  |  |
| --- | --- |
| **Cycle** | Choose an item. |
| **Flow** | Choose an item. |
| **Associated with** | Choose an item. |

|  |  |
| --- | --- |
| **Child Delivery Problems (if Applicable)** | Click or tap here to enter text. |

1. **DIETARY HABITS**

|  |  |
| --- | --- |
| Diet | Choose an item. |
| **SCHEDULE** | **MENU** | **QUANTITY** |
| EARLY MORNING | Click or tap here to enter text. | Click or tap here to enter text. |
| BREAK FAST | Click or tap here to enter text. | Click or tap here to enter text. |
| MID MORNING | Click or tap here to enter text. | Click or tap here to enter text. |
| LUNCH | Click or tap here to enter text. | Click or tap here to enter text. |
| EVENING | Click or tap here to enter text. | Click or tap here to enter text. |
| NIGHT | Click or tap here to enter text. | Click or tap here to enter text. |
| Consumption of Tea/ Coffee | Choose an item. |
| If **YES**:* How many times a day?
* Along with the above schedule or even separately?
* With or without biscuits/namkeens/ snacks
 | Click or tap here to enter text.Click or tap here to enter text.Click or tap here to enter text. |

|  |  |
| --- | --- |
| **Addictions (if Any)**Smoking, Tobacco chewing, Alcoholic Beverage, etc. | Choose an item.If **YES**,1. State what addiction you have:

Click or tap here to enter text.1. State Frequency of Consumption (per day/week/month/occasionally):

Click or tap here to enter text.1. Quantity of Consumption (per day/week/month/occasionally):

Click or tap here to enter text. |

**Enclosures**

1. Medical Report and opinion on your state of health from your physician, if any.
2. Copies of reports of investigations, including blood reports, X-ray/ MRI/ ECG reports, etc., if any.