

<b>Case history</b>	<b>Sr. No.</b>
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<b>Name</b>					
<b>Sex</b>	M / F	<b>Age</b>		<b>Marital Status</b>	B / S / M / W
<b>Occupation</b>				<b>Date</b>	

<b>1.0</b>	<b>Presenting complaint:</b>		
	<b>Onset</b>		
1.1	When it started?		
1.2	How did it start?		
	<b>Progress</b>		
1.3	Has the problem increased / decreased so far?	I / D	
	<b>Site</b>		
1.4	Where the pain is located?		
1.5	Does it stay in one place?	Yes / No	
1.6	Does it move or spread?	Yes / No	
	<b>Severity</b>		
1.7	Is it a mere discomfort?	Yes / No	
1.8	Is it acute pain which interferes with the activities?	Yes / No	
1.9	Whether it keeps him awake at night?	Yes / No	
	<b>Timing</b>		
1.10	When did it start?		
1.11	When does it come?		
1.12	When does it go?		
	<b>Modalities</b>		
1.13	What brings it on or worsens it?		
1.14	What relieves it?		
1.15	What is its relationship with rest & exertion?		

<b>2.0</b>	<b>Respiratory Complaints</b>	<b>Reply</b>	
2.1	Cough?	Dry /Wet	
2.2	Sputum?	Thin (Watery) /Thick	
2.3	Colour of sputum	White /Yellow /Greenish / Red	
2.4	Blood with cough	Yes /No /Occasionally	
2.5	Breathlessness When?	Yes / No	
2.6	Chest pain on		
	What brings it?		
	What relieves it?		
2.7	Allergies?		

<b>3.0</b>	<b>Digestive Complaints:</b>	<b>Reply</b>	
3.1	Difficulty in swallowing?	Yes / No	
3.2	Nausea - Vomitting?	Yes / No	
3.3	Colour / nature of vomitus?		
3.4	Indigestion?	Yes / No	
3.5	Constipation?	Yes / No	
3.6	Flatulence (Gas)?	Yes / No	
3.7	Loose Motions? Colour?	Yes / No	
3.8	Sticky / foul-smelling stools	Yes / No	
3.9	Mucus / blood in stools?	Yes / No	
3.10	Pain in abdomen?	Yes / No	
	Where?		
	When?		
3.11	Nature of Pain?		
3.12	What causes pain?		
3.13	What relieves Pain?		
3.14	Itching in the anus?	Yes / No	
3.15	Yesterday's diet		
	Veg or Non-veg		

<b>4.0</b>	<b>Cardiovascular Problem:</b>	<b>Reply</b>	
4.1	Breathlessness?	Yes / No	
	When?		
4.2	Palpitations?	Yes / No	
4.3	High BP?	Yes / No	
4.4	Chest Pain?	Yes / No	
	When?		
	Where?		
4.5	What causes?		

4.6	What relieves it?		
4.7	Odema (Swelling) on feet?	Yes / No	

<b>5.0</b>	<b>Bone / Muscle Problem:</b>	<b>Reply</b>	
5.1	Pain / cramps in muscles?	Yes / No	
5.2	Weakness in legs?	Yes / No	
5.3	Loss of function / movements?	Yes / No	
5.4	Pain in Joints?	Yes / No	
5.5	Pain in Joints?	One / Many	

<b>6.0</b>	<b>Complaints of nervous system:</b>	<b>Reply</b>	
6.1	Headache?	Yes / No	
	Where?		
	When?		
	What causes?		
	What relieves it?		
6.2	Changes in memory / intelligence?	Yes / No	
6.3	Changes in speech / language?	Yes / No	
6.4	Paralysis?	Yes / No	
6.5	Loss of control over passage of urine	Yes / No	
6.6	Loss of control over passage of stools	Yes / No	
6.7	Disturbance of - Vision	Yes / No	Left / Right
6.8	Disturbance of - Hearing	Yes / No	Left / Right
6.9	Disturbance of - Taste	Yes / No	
6.10	Disturbance of - Smell	Yes / No	
6.11	Disturbance of - Touch	Yes / No	

<b>7.0</b>	<b>Uro-genital Problem:</b>	<b>Reply</b>	
7.1	Urination - Interrupted?	Yes / No	
7.2	Urination - Burning?	Yes / No	Start / End
7.3	Urination - Painful	Yes / No	Start / End
7.4	Urination - Excessive / frequent	Yes / No	
7.5	Urination - Colour		

8.0	Whether patient had similar problem in the past?	Yes / No	
9.0	Family history of this problem or any other problem?	Yes / No	
10.1	Treatment sought / received so far?	Yes / No	
10.2	What extent it has helped?		

<b>11.0</b>	<b>General Health of the Patient:</b>	<b>Reply</b>	
11.1	Energy level	Good / Fair / Poor	
11.2	Immunity status (Birth time)	Morning / Afternoon / Night	
11.3	Digestion		
	Digestion - Good appetite?	Yes / No	
	Digestion - Can you eat well?	Yes / No	
	Digestion - Regular motions?	Yes / No	
11.4	Thirst?	Normal / Abnormal	
11.5	Urination? Any problem?	Yes / No	
11.6	Sleep		
	Sleep - Sound sleep?	Yes / No	
	Sleep - Refreshing?	Yes / No	
	Sleep - Nap in the afternoon?	Yes / No	
11.7	Weight		
	Weight - Stable?	Yes / No	
	Weight - Steadily gaining?	Yes / No	
	Weight - Losing weight?	Yes / No	
11.8	Addictions	Tea/coffee/drink/smoking/tobacco	
11.9	Menses		
	Menses - Regular	Yes / No	
	Menses - Pain free?	Yes / No	
11.10	High BP?	Yes / No	
11.11	Diabetes?	Yes / No	
	When last examined?		
11.12	Diet		
	Diet - Break Fast		
	Diet - Lunch		
	Diet - Dinner		

<b>12.0</b>	<b>Whether any of the following symptoms were noticed by Patient? If yes When? (Diabetes)</b>		
12.1	Excessive & frequent Urination		
12.2	Dryness of mouth & excessive thirst		
12.3	Excessive hunger		
12.4	Loss of weight		
12.5	Weakness, fatigue & body ache		
12.6	Mental fatigue & lack of concentration		
12.7	Wound infection & delayed healing		
12.8	Easy susceptibility to infections of the skin, gums and respiratory system		
12.9	Intense itching all over the body, especially that of the genital parts		
12.10	Frequent changes in the sharpness of vision and the spectacle number		
12.11	Numbness of limbs and an abnormal increase or decrease in skin sensations		
12.12	Sexual debility or impotence		
12.13	Diabetic unconsciousness		
12.14	Sudden weigh again after 45 years		
12.15	Coronary heart disease		
12.16	Cerebral haemorrhage		

<b>13.0</b>	<b>Discuss following factors with Patient to ascertain possibility of BP.</b>		
13.1	Hereditary		
13.2	Mental tension & approach		
13.3	Excessive intake of salt		
13.4	Obesity		
13.5	Sedentary life		
13.6	Smoking		
13.7	Alcohol consumption		