

DOCTOR JI

HEAL POINT

1. Patient Details

Name: _____

Age: _____ years

Gender: Male Female Other

Date of Birth (DOB): ___/___/_____

Contact Number: _____

Aadhar Number: _____

Blood Group: _____

Height: _____ cm

Weight: _____ kg

Marital Status: Single Married Divorced
 Widowed

2. Presenting Complaints (Chief Complaints)

- _____

- Onset: _____
- Duration: _____
- Severity: _____ Mild Moderate
- Severe Associated Symptoms: _____

3. History of Present Illness (HOPI)

- _____

- Timeline: _____
- Previous Interventions: _____

4. Past History

	Details
Field Surgical History:	
Hospitalizations:	
Chronic Illnesses:	

5. Medical History

DOCTOR JI

Condition	Status	Duration	Treatment/Management
Blood Pressure (BP):	<input type="checkbox"/> Normal <input type="checkbox"/> High <input type="checkbox"/> Low		
Diabetes:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Thyroid Disorders:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No		

(TB):			
Leprosy:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other Conditions:			

6. Family History

Disease/Condition	Family Member	Relation
<input type="checkbox"/> _____ _____	<input type="checkbox"/> _____ _____	<input type="checkbox"/> _____ _____
<input type="checkbox"/> _____ _____	<input type="checkbox"/> _____ _____	<input type="checkbox"/> _____ _____
<input type="checkbox"/> _____ _____	<input type="checkbox"/> _____ _____	<input type="checkbox"/> _____ _____

7. Treatment History

- Current Medications:

- _____ (Dosage: _____)
- _____ (Dosage: _____)

- Previous Treatments:

- _____ (Outcome: _____)
- _____ (Outcome: _____)

8. Drug Allergies

Drug Name	Allergic Reaction	Severity	Treatment
		<input type="checkbox"/> Mild <input type="checkbox"/> Severe	

9. Menstrual History (if applicable)

- Menarche: _____ years
- Menstrual Cycle: _____ days
- Regularity: Regular Irregular
- Duration of Bleeding: _____
- Menstrual Symptoms: _____

10. Personal History

Factor	Details
Alcohol Use:	<input type="checkbox"/> No <input type="checkbox"/> Yes, Frequency: <input type="checkbox"/> _____
Smoking: Sexual	<input type="checkbox"/> No <input type="checkbox"/> Yes, Duration: <input type="checkbox"/> _____
History:	
Occupation:	<input type="checkbox"/> No <input type="checkbox"/> Yes, Any Issues: _____
Sleep Pattern:	<input type="checkbox"/> Hours: <input type="checkbox"/> _____

11. Dietary History

- Dietary Preferences: Vegetarian Non-Vegetarian Vegan
 Other:
- Eating Habits: Regular Irregular | Junk Food Healthy
- Food Allergies: Yes, Allergy to: _____ No

12. General Physical Examination

Observation	Findings
Vital Signs:	<input type="checkbox"/> BP: <input type="checkbox"/> _____ <input type="checkbox"/> HR: <input type="checkbox"/> _____ <input type="checkbox"/> RR: <input type="checkbox"/> _____ <input type="checkbox"/> Temp: <input type="checkbox"/> _____
General Appearance:	<input type="checkbox"/> Normal <input type="checkbox"/> Rash <input type="checkbox"/> Lesions
Skin:	
HEENT:	
Lymph Nodes:	<input type="checkbox"/> Palpable <input type="checkbox"/> Non-Palpable <input type="checkbox"/> Normal
Chest & Lungs:	<input type="checkbox"/> Abnormal Findings <input type="checkbox"/> Normal
Abdomen:	<input type="checkbox"/> Abnormal Findings <input type="checkbox"/> Normal
Extremities:	<input type="checkbox"/> Abnormal Findings <input type="checkbox"/> Normal

13. Systemic Examination

System	Findings
Cardiovascular:	
Respiratory:	
Gastrointestinal:	
Genitourinary:	
Neurological:	
Musculoskeletal:	
Integumentary:	

14. Investigations

- **Laboratory Tests:**
 - [Insert Test] – [Results] | [Date]
 - [Insert Test] – [Results] | [Date]
- **Imaging:**
 - X-ray: _____
 - CT Scan: _____
 - MRI: _____

- **Other Diagnostics:**

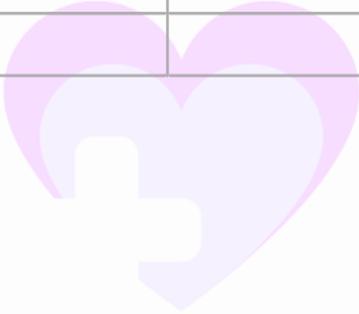
- ECG: _____
- Endoscopy: _____

15. Provisional Diagnosis

- _____
- _____

16. Examination Details

Information	
Field Completed	
By: Date:	
Signature:	



DOCTOR JI