AYUR SHIELD
AYURVEDA FOR IMMUNITY

# AYURSHIELD IMMUNITY CLINICS : AUTOIMMUNE CASES

Detailed Assessment for Autoimmune/Auto-inflammatory cases

**Name of the patient.....**

**Age/Gender: ..... UID No..... Date & Time of assessment: .....**

| | | |
|---|---|---|
| **1. History of present illness** | | |
| a. | Onset/Duration | |
| b. | Severity | |
| c. | Intermittent/Continuous | |
| d. | Exacerbating or relieving factors | |
| e. | Associated symptoms | |
| **2. Key Symptoms** | | |
| a. | Pain | |
| b. | Rashes & Skin lesions | |
| c. | Immune/Systemic symptoms | |
| d. | Stiffness | |
| e. | Malignancy/Weight loss | |
| f. | Swelling | |
| **3. Past Medical History** | | |
| a. | Previous Rheumatological disease | |

| | | |
|---|---|---|
| b | Other Autoimmune conditions | |
| c. | Details of recent infections if any | |
| d | Surgical procedures including transplants | |
| e. | Other medical conditions | |
| **4. Drug History** | | |
| a. | Analgesics | |
| b. | DMARD's/Immunosuppressants | |
| c. | Other prescribed medications: | |
| d. | Supplements or Over the counter medications | |
| e. | AYUSH Medications | |
| **5. Allergies** | | |
| **6. Family history** | | |
| a. | Autoimmune diseases | |
| b. | Others | |
| **7. Details of Screening/investigations or detailed evaluation(s)** | | |

**Name & Signature of Evaluator:**