AYUR SHIELD
AYURVEDA FOR IMMUNITY

AYURSHIELD IMMUNITY CLINICS: CASE SHEET

MRD No:_____

Name of the patient:				
Age:		**Gender:**		
Address				
Referred case: Yes/No		**If yes referred by/from:**		
Date & Time:				
Accompanied by:				

Presenting Complaints:

History of present illness:

Past Medical History

Disease	**Status** (Mark Y/N)	**Details/Duration**	**Presently on Medication** (Mark Y/N)	**Remarks**
Diabetes Mellitus				
Autoimmune/auto inflammatory diseases		If yes, please complete annexure 4		
Hypertension				
Dyslipidemia				
Cardiac disease				
Neurological disorders				
Bleeding disorders				
Thyroid dysfunction				
Liver Dysfunction				
Renal Dysfunction				
Pulmonary disorders				
Others:				

Present Medications if any:
(Provide Generic name with strength dose and timings)

Previous Investigations:

Personal History:

Diet	Appetite	Bowel
Bladder	Sleep	Sattva
Allergy	Marital Status:	Satmya
Menstrual History:	Prakriti	

Addictions:

Birth History & Vaccination Status (for Pediatric cases only):

Physical Examination & Vital parameters:

General Examination

Pulse	BP	Temperature
SPO2	Height	Weight
Pallor:	Odema	Cynosis
Respiration	Lymphnodes	Icterus

Nutritional Screening
BMI:

Nutritional Status: Normal/Under nourished/Over nourished

Special Diet required: Yes/No If yes indication:

Findings on Examination:

Provisional Diagnosis:

Immunity status based on assessment:

Investigations: CBC, ESR, CRP, IgE, LFT, RFT, FBS

Diagnosis:

Details of interventions

Internal Medications	Treatments

Advices:

Name & Sign of the Consultant: **Name & Sign of the Medical Officer:**