

Client Medical History Format

|  |
| --- |
| **Preliminary details** |
| Name |  |
| Age |  |
| Contact Number |  |
| City |  |
| Occupation |  |

|  |
| --- |
| **Marriage History** |
| Year of Marriage |  |
| Duration of Active Married Life |  |
| Members of family |  |
| No. of Children |  |

[ ]  Asthma

[ ]  Diabetes

[ ]  Hypertension

|  |
| --- |
| **General History** |
| History of any previous illness |  [ ]  Any Other Chronic illness[ ]  Thyroid |
|  |
| History of any Viral infections |  |
|  |
| History of Allergies | [ ]  Measles[ ]  Mumps |
| History of any Previous Surgeries | [ ]  Jaundice[ ]  Rubella[ ]  Chicken Pox |
| Previous Contraceptive History | [ ]  Typhoid |
| If Yes Pls, specify[ ]  No[ ]  Yes[ ]  No[ ]  Yes[ ]  Food[ ]  Medicine[ ]  Paralysis[ ]  Blood infections[ ]  Skin Diseases |

[ ]  Regular

[ ]  Less

[ ]  More

[ ]  Non-Vegetarian

[ ]  Vegetarian

|  |
| --- |
| **Personal History** |
| Height |  |
| Weight |  |
| Dietary History |  |
| Appetite |  |
| Bowel Habits |   |
| Urine |  |
| Sleep Pattern |  |
| Exercise | [ ]  Yes |
| Addictions |  |

[ ]  Constipated

[ ]  Specify- What do you follow?

No of Hours

[ ]  Specify if any issue

[ ]  Normal

[ ]  No

Yes

|  |
| --- |
| **Menstrual History** |
| Age of Menarche |  |
| Menstrual Cycle (in terms of days) |  |
| Flow |  |
| No. of Days |  |

[ ]  2-3

[ ]  3-5

[ ]  5-7

[ ]  <7 days

[ ]  Painful

[ ]  Excess

[ ]  Moderate

[ ]  Scanty

[ ]  Less

[ ]  Regular

[ ]  Irregular

[ ]  Yes

[ ]  No

[ ]  Specify- What do you follow?

|  |
| --- |
| **Obstretic History** |
| Last Delivery Month/Year |  |
| Gravid- How many times has you conceived? |  |
| History of any Abortions/ Miscarriage |  |
| History of Premature/ Delayed Labor |  |
| Total Deliveries |  |
| Nature of delivery |  |
| Any Complications during Pregnancy[ ]  Regular[ ]  Irregular | [ ]  Forceps[ ]  Normal[ ]  C-section |
| Any Complications during labor |  |
| History of any postdelivery complications |  |

|  |
| --- |
| **Lactation Questionnaire** |
| How is your nipple shape? | [ ]  Normal[ ]  Flat[ ]  inverted |
| What was the baby's birth weight? |  |
| What is the baby's weight now? |  |
| How many times a day do you breastfeed? |  |
| how long does each breastfeeding session last? |  |
| how is your baby doing? |  |
| has your baby gained weight |  |
| Are you in pain when breastfeeding |  |
| Do you feel uncomfortable breastfeeding around others or in public? |  |
| For how how long do you intend to breastfeed? |  |