

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? |  |