NIHS RE-LIFE HOSPITALS LTD

(Smart Integrated Medical Tourism Hospital)

NIHS Medical Robot

PATIENT HISTORY FORM

Name : _____ Age : _____ Sex : ☐ Male ☐ Female

Contact No. : _____. Alternate No. : _____ Message (Acceptable) : ☐ Yes ☐ No

Medical History : Have You Ever Been Treated For Any Of The Following Medical Conditions?

☐ Arthritis / Osteoporosis ☐ Diabetes ☐ High B.P. ☐ Irritable Bowel ☐ Cancer ☐ Depression / Anxiety ☐ Thyroid

☐ Heart Problems / Hyper Lipidemias, High Cholesterol ☐ Lung Problems / Asthma / COPD / Bronchitis ☐ HIV / STD

☐ Alcohol / Drug Abuse ☐ Others _____

1) Have You Ever Been Hospitalized Overnight? ☐ Yes ☐ No 2) Have You Been Hospitalized (last Five Years) ☐ Yes ☐ No

3) Have You Ever Had Surgery? ☐ Yes ☐ No Details Of Surgery And Hospitalization _____

_____

Medications and Allergies (A Complete List Of Everything You Take On A Regular Basis,) _____

_____

Do You Take Any Supplements ☐ Calcium ☐ Vitamin D ☐ Fish Oil ☐ Multivitamin ☐ Nutraceuticals ☐ Nil

Family History : (Please List Any Known Medical Problems For The Relatives Listed Below) :
For Example : Diabetes, Cancer (Breast / Colon / Ovarian / Prostate / Skin), Heart Attacks, High Blood Pressure, Alcohol, Drug Abuse, Depression, Osteoporosis

Mother : _____

Father : _____

Brothers / Sisters : _____

Children : _____

Other : _____

_____

_____

_____

Habits :

What Do You Do For Exercise? _____

How Often? _____

Tobacco (Chew / Smoke) : _____ Per Day

Alcohol (Beer / Wine, etc.) _____ Per Day

Street Drugs (Marijuana , etc.) : _____

Caffeine (Coffee / Tea / Soda) : _____ Per Day

Any Trouble In Sleeping? ☐ Yes ☐ No

Describe You Eating Habits : (Poor, Well-Balanced, Vegetarian, Gluten-Free Etc) _____

Do You Eat Out More Than Twice A Week? ☐ Yes ☐ No

Social History :

Ary You Retired? ☐ Yes ☐ No

Work Type : _____

Do You Enjoy Your Job ? _____

_____

Any Major Stresses In Your Llife?

_____

_____

_____

_____

_____

Relationship Status :

☐ Married ☐ Single ☐ Widowed

☐ Divorced / Separated

☐ In A Relatonship

How Long? _____

Who Do You Live With : _____

How Many Children Do You Have?

_____

Do You Feel You Ever Have Been Abused (Verbally, Physically Or Sexually?

☐ Yes ☐ No

Do You Wear Seatbelts / Helmets?

☐ Yes ☐ No ☐ Sometimes

Do You Wear Sunscreen?

☐ Yes ☐ No ☐ Sometimes

Do You Have An Eye Exam At Least Every Two Years? ☐ Yes ☐ No

Do You Have A Dental Exam At Least Yearly? ☐ Yes ☐ No

PATIENT **CONSULTANT**

REVIEW OF SYSTEMS (Please Circle Any Current Symptoms Below)

COMMON FOR MEN AND WOMEN

GENERAL SYMPTOMS:

Fever, Unexplained Tiredness, Swollen Glands, Excessive Thirst, Feeling Unusually Hot Or Cold, Easy Bruising Or Bleeding, Passing Out

EYES

Vision Loss, Eye Pain, Blurred Vision

BREASTS

Lumps, Skin Changes, Nipple Discharge

EARS / NOSE / MOUTH & THROAT :

Sore Throat, Running Nose, Hearing Loss, Problems With Mouth, Voice Changes

LUNGS & HEART

Chest Pain / Pressure, Irregular Heart Beat, Cough / Wheezing / Breathing Trouble

SKIN

Rashes, Changing Moles, Changes In Hair / Skin / Nails

NEUROLOGICAL

Unusual Or New Headaches, Weakness Or Numbness, Falling.

ABDOMEN

Nausea, Vomiting, Pain, Heartburn, Diarrhea, Constipation, Bloody Stools

SLEEP

Difficulty In Falling Asleep, Frequent Awakening

MUSCULOSKELETAL

Joint / Muscle Pain, Muscle Weakness

MOOD

Worry Too Much, Felt Down And Depressed in the Last Two Weeks, Loss Of Desire To Do Things You Used To Enjoy, Thoughts Of Self Harm Or Sucide

MEN ONLY

Difficulty Starting Or Weak Stream, Difficulty Getting / Maintaining Erections, Feeling Like Bladder Won't Empty, Getting Up At Night To Urinate, Testicular Pain / Lumps, Possible Sexually Transmitted Infections, Sexual Weakness, Leaking Urine.

WOMEN ONLY

Heavy Periods, Bleeding After Menopause, Sexual Concerns, Unusual Vaginal Discharge, Possible Sexually Transmitted Infections, Severe Pain With Periods, Leaking Urine.

WOMEN ONLY

Still Having Peiods? Yes ☐ No

☐ Regular ☐ Irregular

Date Of Last Period : _____ Birth Control Type : _____

Hysterectomy : ☐ Yes ☐ No

If Yes, What Age? _____

Due To What? _____

Number Of Pregnancies : _____

_____ Vaginal Deliveries

_____ C-Section Deliveries

_____ Other (Stillbirth, Miscarriage / Abortion)

Diabetes In Pregnancy? ☐ Yes ☐ No.

Have You Ever Had An Abnormal Pap Or Colposcopy? ☐ Yes ☐ No

OTHER

List Any Symptoms Not Mentioned : _____

_____

ASSESSMENT & COMMENTS BY CONSULTANT

_____

_____

_____

_____

PATIENT **CONSULTANT**

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MENTAL STATUS EXAM

Client Name :	Date :

OBSERVATIONS					
Appearance	☐ Neat	☐ Disheveled	☐ Inappropriate	☐ Bizarre	☐ Other
Speech	☐ Normal	☐ Tangential	☐ Pressured	☐ Impoverished	☐ Other
Eye Contact	☐ Normal	☐ Intense	☐ Avoidant	☐ Other	
Motor Activity	☐ Normal	☐ Restless	☐ Tics	☐ Slowed	☐ Other
Affect	☐ Full	☐ Constricted	☐ Flat	☐ Labile	☐ Other
Comments:					

MOOD						
☐ Euthymic	☐ Anxious	☐ Angry	☐ Depressed	☐ Euphoric	☐ Irritable	☐ Other
Comments:						

COGNITION				
Orientation Impairment	☐ None	☐ Place	☐ Object	☐ Person ☐ Time
Memory Impairment	☐ None	☐ Short-Term	☐ Long-Term	☐ Other
Attention	☐ Normal	☐ Distracted	☐ Other	
Comments:				

PERCEPTION				
Halucinations	☐ None	☐ Auditory	☐ Visual	☐ Other
Other	☐ None	☐ Derealization	☐ Depersonalization	
Comments:				

THOUGHTS					
Sucidality	☐ None	☐ Idealion	☐ Plan	☐ Intent	☐ Self-Harm
Homicidality	☐ None	☐ Aggressive	☐ Intent	☐ Plan	
Delusions	☐ None	☐ Grandiose	☐ Paranoid	☐ Religious	☐ Other
Comments:					

BEHAVIOR				
☐ Cooperative	☐ Guarded	☐ Hyperactive	☐ Aglated	☐ Paranoid
☐ Stereotyped	☐ Aggressive	☐ Bizame	☐ Withdrawn	☐ Other
Comments:				

INSIGHT	☐ Good	☐ Fair	☐ Poor	☐ Comments
JUDGMENT	☐ Good	☐ Fair	☐ Poor	☐ Comments

ADDICTION STATUS EXAMINATION

SUBSTANCE USE					
DRUG CATEGORY (circle each substance used)	Age when you first used this	How much & how often did you used this?	How many years did you used this?	When did you last used this?	Do you currently use this?
ALCOHOL					Yes ☐ No ☐
CANNABIS : Marijuana, Hashish, Hash oil					Yes ☐ No ☐
STIMULANTS : Cocaine, Crack					Yes ☐ No ☐
STIMULANTS : Methamphetamine-Speed, ice, Crank					Yes ☐ No ☐
AMPHETAMINES / OTHER STIMULANTS : Ritalin, Benzedrine, Dexedrine					Yes ☐ No ☐
BENZODIAZEPINES / TRANQUILIZERS : Valium, Librium, Halcion, Xanax, Diazepam, "Roofies"					Yes ☐ No ☐
SEDATIVES / HYPNOTICS / BARBITURATES : Amytal, Seconal, Dalmane, Quaalude, Phenobarbital					Yes ☐ No ☐
HEROIN					Yes ☐ No ☐
STREET OR ILLICIT METHADONE					Yes ☐ No ☐
OTHER OPIOIDS : Tylenol #2 & #3, 282'S, 292'S, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid					Yes ☐ No ☐
HALLUCINOGENS : LSD, PCP,STP, MDA, DAT, Mescaline, Peyote, Mushrooms, Ecstasy (MDMA), Nitrous Oxide					Yes ☐ No ☐
INHALANTS : Glue, Gasoline, Aerosols, Paint Thinner, Poppers, Rush, Locker Room					Yes ☐ No ☐
OTHER : Specify) _____ _____ _____					Yes ☐ No ☐