Indian Institute of Science Education and Research Bhopal

HEALTH DATA SHEET

NAME:		**AGE/ SEX:**	
DEPARTMENT:		**PF NO/ ROLL NO:**	
BLOOD GROUP:		**CONTACT NO:**	
FULL ADDRESS:			

SL NO	QUESTIONS	YES	NO	DETAILS
1.	Do you have any minor or major complaint about your health			
2.	Are you taking any medication? If so, what?			
3.	Do you have any allergies? If yes describe			
4.	Have any of your blood relatives suffered from:			
	• High Blood Pressure			
	• Heart Disease			
	• Tuberculosis			
	• Stroke (Paralysis or Hemorrhage in Brain)			
	• Diabetes			
	• Cancer			
	• Any other disease (describe)			
5.	Do you take some alcoholic beverages almost every day?			
6.	Do you use tobacco or smoke? If yes, what and how much each day?			
7.	Do you have fainting spells?			
8.	Do you have frequent headaches?			
9.	Do you feel that your eyesight is failing?			
10.	Has there been any change in the appearance of any birth marks, warts or moles on your skin in the past 6 months?			
11.	Do you have any skin sores that don't heal quickly?			
12.	When you walk upstairs, do you get a feeling of pain, tightness, burning or choking in your chest?			
13.	Do you have occasional swelling of your ankles?			
14.	Do you become unusually short of breath when you walk up one flight of stairs?			
15.	Do you get pain in your legs on walking which goes away quickly after you stop?			

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16.	Do you have trouble swallowing?			
17.	Have you ever vomited any blood material?			
18.	Have you ever had any operations or been advised an operation?			
19.	Are you thirsty a good deal of the time and do your drink large amount of liquids?			
20.	Have u had a cough that started in the last 6 months and lasted more than a month?			
21.	Have you ever had epilepsy, fits or convulsions?			
22.	Do you ever feel so depressed that it interferes with your jobs or with your doing housework?			
23.	Have you ever been treated for nervous or mental illness?			
24.	Do you feel that you need medical or psychiatric help because of nervousness?			
25.	Do you have hernia?			
26.	Do you have hemorrhoids or piles?			
27.	Have you been told by any doctor that you suffer from any of the following conditions?			
	• Tuberculosis			
	• Asthma			
	• Anemia			
	• Diabetes • Rheumatic Fever			
	• A stomach ulcer, duodenal ulcer or a peptic ulcer			
	• Cancer			
	• Syphilis or other venereal disease			
	• An abnormal finding in a chest 'X'RAY			
	• Angina pectoris or heart disease			
	• High blood pressure			
28.	**FOR WOMEN ONLY** Have you ever noticed any bleeding between menstrual periods?			
29.	Are /were your period Is irregular?			
30.	Do you have a lump in your breast?			