MEDICAL DETAILS

NAME LEBOIX Liliane AGE 64
Male Female

1. PRESENT ILLNESS:

List of present health problems with duration of each:

NO	DESCRIPTION	DURATION
01.	Stress and nervous tension	always
02.	osteoarthritis	3 years
03.	Constipated	always
04.		
05.		
06.		

2. A BRIEF DESCRIPTION OF PRESENT ILLNESS :
stress due to work three nights a week

How it started and progressed:

3. DETAILS OF MEDICAL INVESTIGATIONS DONE, IF ANY:

without

4. DETAILS OF TREATMENTS DONE IF ANY:

/

5. CURRENT MEDICATION :

/

6. ALLERGIES IF ANY :

no

7. STATE OF DIGESTION :

APPETITE	NORMAL	LESS	MORE
	✓		
BOWEL HABITS	REGULAR	IRREGULAR	
		✓	
URINE QUANTITY	ADEQUATE	LESS	MORE
	✓		
SLEEP	SOUND	DISTURBED	
		✓	

8. MENSTRUATION: finished

Cycle	Regular	Irregular	
Flow	Normal	Less	More
Associated with	Pain	Clots	Head-ache

9. MARRITAL STATUS

Married	Single
✓	✓

common life

10 DIET

DIETARY HABITS	VEGETARIAN	NON VEGETARIAN	
	X	X	
MODE OF INTAKE	REGULAR	IRREGULAR	
	X		
ADDICTIONS IF ANY	SMOKING	ALCOHOL	OTHERS
	no	no	no

11. Other important information if any :

Chronic constipation

~~Doctor~~ hip pain

Daily routine **Underline Your Answer**

Get up from bed at.....Wake up with /(without alarm)

Are you rested, happy and alert? (Yes)..No Varies

I go to sleep at 1h.eo..... Do you fall asleep easily? Yes..(No) Varies
morning

Du you usually sleep all night without interruptions? Yes...No
(Varies)

Do you sleep daytime ? Yes...No (Varies)

Do you put aside time for yourself every day? Yes..(No) Varies

Do you practise any form of relaxation or meditation? Yes..(No)

Apetite – digestion – bowel movement

Do you empty your bowel daily without difficulty? Yes..(No) Varies

At what time? Early morning After breakfast (Before lunch) After lunch
Evening Varies

Is the stool often: (Hard/dry) (Loose) Soft/welformed

Do you sometimes have altering constipation – diarrea (Yes)..No Varies

Do you have gases or swollen stomach Yes(..No)
Varies

Do you drink something directly when you get up Yes...No)

Do you feel real hunger – before breakfast? Yes..(No)

before lunch? (Yes..)No

before dinner? Yes(..No)

Do you often feel the urge for something in between meals? Yes..(No)

Do you usually eat even if you are not really hungry? Yes..(No)

Do you feel heaviness, drowsiness or tired after eating yes..(No)

What are your common mealtimes (Regular) / irregular

Breakfast at ....10h00..... Lunch at.....13h.....

Dinner at.....21h.....In between meals .....no..... .....

What do you usually eat (take the last few days as an example)

Brekfast... Juice fruit

Lunch... boiled végétables

Dinner... rice, carry, fish

Snacks... hot herbal tea

What do you drink with food? water or champagne

Between meals?

water

If you drink coffee – how many cups a day? no coffee

Is it something that you do not like or do not feel well of?

Fat or fried food. no Tastes: (Sweet) sour (salt) pungent bitter astringent

Other ..... Sugar .....

Is there something you especially like ? ... Cake

What kind of sweets do you usually eat? Cookies icecream sweets (chocolate) (fruit) other Cake

Is this with meals or separate?

Do you regularly use: Curd (yoghurt) (cheese) milk cream (margerine) meat (fish) (egg)