



Aayushman Aadhar
An initiative of Aadhar Housing Finance Ltd.
Implementation partner – Y4D Foundation

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Patient Details:

Name: Age:

SPO2: Temp: Sex: Contact:

Previous medicines (if any):

Basic diagnosis:

Have you ever had?

- | | |
|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Epilepsy Seizures | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Gallstones | <input type="checkbox"/> Neurological Disorder |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Digestive Problem | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Ulcer Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Emotional Disorder |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Use a C-PAP machine | |

Other Illness:

Recommendation:

Doctor's name & Sign.

Representative's sign

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