



## SARAS AMBULANCE SERVICES

Ref. No.

### HISTORY SHEET

**Patient Name :** \_\_\_\_\_ **Age & Sex** \_\_\_\_\_

**Date and Time of Medical Evacuation :** \_\_\_\_\_

**HISTORY OF PRESENTING COMPLAINS :** \_\_\_\_\_

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**HISTORY OF PRESENT ILLNESS :** \_\_\_\_\_

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### PAST HISTORY :

### IF YES, DURATION

DM	YES	NO
HT	YES	NO
CAD	YES	NO
COPD	YES	NO

**KOCH'S**

YES	NO
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**PERSONAL HISTORY**

**SMOKING**

YES	NO
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**ALCOHOL**

YES	NO
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FAMILY HISTORY : \_\_\_\_\_

TREATMENT HISTORY : \_\_\_\_\_

DRUG ALLERGY : \_\_\_\_\_

OTHERS HISTORY : \_\_\_\_\_

**PRE FLIGHT EXAMINATION**

Level of consciousness

Conscious	Unconscious	Drowsy	Altered Sensorium
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TEMP.

BP

HR

RR

PALLOR

YES	NO
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CYNOSIS

YES	NO
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CLUBBING

YES	NO
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ICTERUS

YES	NO
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OEDEMA

YES	NO
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LYMPHADENOPATHY

YES	NO
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**SYSTEMIC EXAMINATION**

1. CVS

S 1

S2

ADDED SOUNDS

2. RESP.

3. PA

LIVER  
SPLEEN  
ASCITIES  
OTHERS

4 CNS

HF  
MOTER  
SUNSURY

CEREBELLAR  
REFLEXES

5. GCS  
Diagnosis

- 1.
- 2.
- 3.

Name & Signature of Escort Team