Outer Cover Page

College Logo

University Logo

Name of the College……

Name of University……

KAMIL-E-TIBB-O JARAHAT

BACHELOR OF UNANI MEDICINE & SURGERY (B.U.M.S.)

SECOND PROFESSIONAL B.U.M.S.

SAREERIYAT WA USOOLE ILAJ

(BED SIDE CLINIC AND PRINCIPLES OF MANAGEMENT)

UNIUG-SUI

PRACTICAL RECORD BOOK

Name of the Student : ----------

Institutional Roll No. : ----------

Academic Year: ----------

Department of Moalajat

Inner First Right Page

UNIVERSITY LOGO

COLLEGE LOGO

NCISM LOGO

COLLEGE NAME……

APPROVED BY

NATIONAL COMMISSION FOR INDIAN SYSTEM OF MEDICINE, NEW DELHI

AFFILIATED TO

UNIVERSITY NAME……

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UNIUG-SUI

PRACTICAL RECORD BOOK

Name of the Student : ----------

Unique AYUSH ID No : ----------

University Register/ Enrolment No.:----------

Institutional Roll No. : ----------

Academic Year: ----------

Department of Moalajat

2nd Right Page-Certificate

UNIVERSITY LOGO

COLLEGE LOGO

NCISM LOGO

COLLEGE NAME……

APPROVED BY

NATIONAL COMMISSION FOR INDIAN SYSTEM OF MEDICINE, NEW DELHI

AFFILIATED TO

UNIVERSITY NAME……

CERTIFICATE

This is to certify that, Mr./Mrs./Miss…… (Name of student) bearing Roll No…… and University Register/Enrolment No…… has satisfactorily completed all the Practical of **SAREERIYAT WA USOOLE ILAJ (BED SIDE CLINIC AND PRINCIPLES OF MANAGEMENT) UNIUG-SUI** prescribed by the National Commission for Indian System of Medicine as a part of Second Professional B.U.M.S Course.

HEAD OF THE DEPARTMENT

Submitted for the Practical Examination Conducted by …… (University Name), held on ……(date) at ……**.** (College name).

EXAMINERS

Date: ----------
Place: ----------

Internal: ----------
External: ----------

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INDEX

Sr. No.	Date	Name of Practical	Term	Page No.	Signature of Teacher
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INSTRUCTIONS & GUIDELINES

General

1. The common format for the practical prescribed by the NCISM is aiming to maintain uniformity among colleges/institutions across the country.

Instructions to Students

2. The student will prepare the practical record book, including the cover page, first inner page, certificate page, and index page as per the format prescribed by the NCISM here.
3. The student will record in the practical record book handwritten immediately after each practical and get the signature of the concerned teaching faculty.
4. The student will use the specific format/template for recording each practical in the practical record book.

Instructions to Teachers/HOD

5. It is the responsibility of the department to conduct practicals as per the list, schedule, method, etc., specified in the curriculum.
6. The teacher must instruct the student to record his/her work as per the specific format prescribed by the NCISM here (**List of practical and format reference are enclosed herewith**).
7. After each practical, the concerned teacher must verify the completion of the record work and put the signature in the index page.
8. The certificate page of the practical record will be certified and signed by the concerned head of the department along with the departmental seal at the end of the session.
9. Normal values or any other important information confined to the subject, if any, may be printed in the last pages.

Guidelines specific to the subject:

10. The students have to do their practical and record the findings in the relevant template
11. The students have to prepare multiple template sheets according to number of patients visited during practical classes.
12. This should be followed stepwise as the Theory progresses hence
13. The portion of Usoole Ilaj will be added to the case sheet in the third term after completing the theory portion of Usoole Ilaj.

List of practical

S. No	Term	Topic	Format Reference
1	1	All portion of History Taking	I
2	1	History and General Physical Examination	II
3	1	History and General Physical Examination	II
4	1	History, GPE, and Examination of GI System with Usoole Ilaj	III
5	1	History, GPE, and Examination of GI System with Usoole Ilaj	III
6	2	History, GPE, and Examination of Respiratory System with Usoole Ilaj	IV
7	2	History, GPE, and Examination of Respiratory System with Usoole Ilaj	IV
8	2	History, GPE, and Examination of Cardiovascular System with Usoole Ilaj	V
9	2	History, GPE, and Examination of Cardiovascular System with Usoole Ilaj	V
10	2	History, GPE, and Examination of Nabz	VI
11	2	History, GPE, and Examination of Genito System with Usoole Ilaj	VII
12	3	History, GPE, and Examination of the Nervous System with Usoole Ilaj	VIII
`13	3	History, GPE, and Examination of the Nervous System with Usoole Ilaj	VIII
14	3	History, GPE, and Examination of the Nervous system with Usoole Ilaj	VIII
15	3	History, GPE, and Examination of Locomotor System with Usoole Ilaj	IX

Format-I

Rūdād-e-Marīz (History Taking)

A. Patient Profile

a) Name of the Patient: ___ __ __ __ __ __ __ __ __ __ __ __ __ __ __

b) Father's/ Husband's Name: ___ __ __ __ __ __ __ __ __ __ __ __ __ __ __

c) Age: ___ __ __ __ __ __ __ __ __ __ __ __ __ __ __

d) Gender: ___ __ __ __ __ __ __ __ __ __ __ __ __ __ __

e) Address (Local and Permanent): __ ___ ___ ___ ___ ___ __ __ __ __ __ __ __ __

f) Occupation: ___ __ __ __ __ __ __ __ __ __ __ __ __ __ __

g) Religion: ___ __ __ __ __ __ __ __ __ __ __ __ __ __ __

h) Marital Status: ___ __ __ __ __ __ __ __ __ __ __ __ __ __ __

i) Date of Admission: ___ __ __ __ __ __ __ __ __ __ __ __ __ __ __

j) Name of the Consultant: ___ __ __ __ __ __ __ __ __ __ __ __ __ __ __

k) Ward No./ Bed No.: ___ __ __ __ __ __ __ __ __ __ __ __ __ __ __

B. Complaints with Duration

Complaints	Duration
Complaint 1	
Complaint 2	
Complaint 3	

C. History of Presenting illness

Detailed Explanation of each symptom from their **Onset**, **Progression upto present condition**

D. Treatment History of Present disease

E. Past History

i. Non-Curable diseases
   a) Diabetes Mellitus
   b) Hypertension
   c) Hypothyroidism

ii. Major Diseases
   a) H/o- ATT
   b) Surgery
   c) Hospitalization (reason)

iii. Any Co-relation of Past disease with present disease

F. Personal and Socio-economic History

i. Habitat
   a) Condition of Home:
   b) Condition of Ventilation:
   c) Source of Water
   d) Condition of Sanitation

ii. Habits
   a) Food Habit (Vegetarian/ Non-vegetarian)
   b) Sleep (Hours and Condition)
   c) Micturition (D/N)—Number
   d) Defaecation (D/N)—Number

iii. Education
   a) Uneducated
   b) Educated (Level of education)

iv. Income (Personal/ Family income)

v. Relations with Home-mates and Work-mates
   a) Good
   b) Disturbed

G. Family History

Age and Health status of

i. Parents
ii. Spouse
iii. Siblings
iv. Children

(If died, Age and Reason of Death)

H. Gynecological and Obstetric History (in case of Female patient)

i. Age of Menarche
ii. Duration of Menstrual Cycle
iii. Duration of Menstrual Period
iv. Menstrual Flow (Normal/ Scanty/ Profuse)
v. Dysmenorrhea
vi. LMP
vii. Gravidity (G)
viii. Parity (P)
ix. Abortion (A)
x. EDD (in case of Pregnancy)

Part of Obstetric History, taken in Married Female patients

Teacher's Remarks (if any)

Signature of Teacher

Format –II

Imteḥān-e-Marīz Umūmī (General Physical Examination)

A. General Appearance/ Look of the patient:
   i. Looking healthy
   ii. Looking ill

B. Built
   i. Lean and Thin
   ii. Obese
   iii. Normal

C. Nutritional Status
   i. Undernourished
   ii. Over nourished
   iii. Normal

D. Decubitus
   i. Lying down/ lying on side with knees close to chest
   ii. Sitting/ Sitting and leaning forward
   iii. Standing
   iv. Flailing

E. Facies
   i. Normal
   ii. Hippocratic facies/ Moon facies/ Mongoloid facies/ Smiling facies etc.

F. G
   a
   i. Normal
   i
   ii. Abnormal: Waddling gait/ Spastic gait/ High stepping gait/ Scissoring gait/ Ataxic
   t

G. Clubbing of Fingers
   i. Negative
   ii. Positive: Grade 1/ Grade 2/ Grade 3/ Grade 4/ Grade 5

H. Pallor
   i. Negative
   ii. Positive: +/++/+++

I. Icterus
   i. Negative
   ii. Positive: +/++/+++

J. Cyanosis
   i. Negative
   ii. Positive: Central/ Peripheral

K. Edema
   i. Present: +/++/+++
   ii. Pitting/ Not Pitting
   iii. Absent

L. Assessment of JVP:
   i. Normal
   ii. Raised

M. Examination of Lymph Nodes
   i. Site: Circular chain / Vertical chain/ Axillary/ Inguinal/ Epitrochlear
   ii. Palpable/Non-palpable
   iii. Consistency: Soft/ tender/ Non-tender/Rubbery/ smooth/ firm/ Hard
   iv. Number: Single/ Multiple/ Matted

N. General Examination of Skin
   i. Skin color
   ii. Temperature of skin
   iii. Elasticity of skin
   iv. Primary lesions
   v. Secondary lesion

O. General examination of eyes
   i. Symmetry
   ii. Ptosis
   iii. Inflammation
   iv. Bitot's Spot
   v. Arcus/ arcus senilis

P. General examination of Mouth and pharynx
   i. Tongue
   ii. Soft palate
   iii. Hard palate
   iv. Buccal mucosa
   v. Tonsil

Q. Vitals
   i. Pulse rate
   ii. Body Temperature
   iii. Blood Pressure
   iv. Respiratory rate

Teacher's Remarks (if any)

Signature of Teacher

Format-III

Imteḥān-e-Niẓām Hazm (Examination of Gastro-Intestinal System)

A. Inspection of Abdomen
- i. Shape of the Abdomen: Flat/ Sunken/ Distended
- ii. Scars
- iii. Engorged superficial veins
- iv. Visible Peristaltic Movement
- v. Visible Pulsation
- vi. Umbilicus
  - a) Position
  - b) Inverted/ Everted
  - c) Caput medusa
- vii. Swelling
  - a) Negative
  - b) Positive (Site)

B. Palpation of Abdomen
- i. Superficial palpation of all nine regions
  - a) Tenderness: Positive/ Negative (mentioning site/ region)
  - b) Guarding: Positive/ Negative
  - c) Rigidity: Positive/ Negative
- ii. Deep palpation for Organomegaly/ Lump
  - a) Liver: Palpable (size in fingers)/ Non-Palpable
  - b) Spleen: Palpable (size in fingers)/ Non-Palpable
  - c) Lump: Palpable (Site)/ Non-Palpable

C. Percussion
- i. Tympanic note: Positive/ Negative
- ii. Dull Note: Positive (Site)/ Negative

D. Auscultation
- i. Bowel sound: No. of bowel sounds/ minute:
- ii. Borborygmi: Positive/ Negative

E. Provisional Diagnosis:

F. Required investigations

G. Proposed line of treatment (Usoole Ilaj)

Teacher's Remarks (if any)

Signature of Teacher

Format-IV

Imteḥān-e-Niẓām-e-Tanaffus (Examination of Respiratory System)

A. Inspection of Chest
   i. Position of Trachea
   ii. Shape of the Chest
      a) Normal, B/L Symmetrical
      b) Abnormal—Kyphosis/ Lordosis/ Scoliosis/ Pectus Carinaum/ Pectus Excavatum
   iii. Respiratory movements:
      a) Positive B/L symmetrical
      b) Restricted movement: Yes (side)/ No

B. Palpation
   i. Position of Trachea:
   ii. Trail Sign: Present/ absent
   iii. Oliver Sign: Present/ absent
   iv. Expansion of Chest (B/L- Symmetrical and Measurement in cm)
   v. Tactile Vocal Fremitus
      a) B/L Symmetrical
      b) Increased/ Decreased: Yes (Site)/ No

C. Percussion
   i. Percussion Note: Resonant over lung field: Present/ absent (Site)
   ii. Dull note: Negative/ Positive (Site and Character: Woody/ Stony)

D. Auscultation
   i. Breath sound: Vesicular/ Bronchial (Site)
   ii. Added sound
      a) Wheeze: Positive (Site)/ Negative
      b) Crackles: Positive (Site)/ Negative
      c) Pleural Rub: Positive (Site)/ Negative
      d) Whispering Pectoriloqui: Positive/ Negative

E. Provisional Diagnosis:
F. Required investigations
G. Proposed line of treatment (Usoole Ilaj)

Teacher's Remarks (if any)

Signature of Teacher

Format –V

Imteḥān-e-Niẓām-e-Qalb wa Urūq (Examination of Cardio-Vascular System)

A. Inspection
- i. Precordium: Normal/ Bulged out
- ii. Apex beat
  - a) Not visible
  - b) Visible (Location)
- ii. Jugular vein: Normal/ Engorged

B. Palpation
- i. Location of Apex beat
- ii. Parasternal Heave: Positive/ Negative
- iii. Cardiac thrill: Positive/ Negative

C. Percussion
- i. Area of Cardiac dullness: Within limit/ extended (extent)

D. Auscultation
- ii. Heart sounds:
  - a) S1 and S2 clearly audible: Yes/ No
  - b) S3 Audible: Yes/ No
  - c) S4 Audible: Yes/ No
- iii. Murmur: Negative/ Positive (Site)
- iv. Carotid Bruit: Positive/ Negative

E. Provisional Diagnosis:

F. Required investigations

G. Proposed line of treatment (Usoole Ilaj)

Teacher's Remarks (if any)

Signature of Teacher

Format –VI

Imteḥān-e-Nabz (Examination of Pulse)

A. Sites of examination of Nabz:

i. Name the artery, describe its position and make a labeled diagram

B. Assessment of Adilla-e-Nabz

i. Azeem/ Sagheer/ Ghaleez/ Raqeeq/Motadil

ii. Qawi/ Zaeef/ Motadil

iii. Saree/Bati/ Motadil

iv. Mutawatir / Mutafawit/ Motadil

v. Layyin/ Sulb/ Motadil

vi. Khali/ Mumtali/ Motadil

vii. Haar/ Barid/ Motadil

viii. Mustawi / Mukhtalif

ix. Muntazim/ Ghair Muntazim

x. JayeedulWazn/ Raddiul Wazn

C. Assessment of Nabz-e-murakkab (if any)

D. Assessment of Nabz of specific Diseases

Teacher's Remarks (if any)

Signature of Teacher

Format –VII

Imteḥān-e-Niẓām-e-Baul wa Tanāsul (Examination of Genito-Urinary system)

A. Inspection
   i. Swelling over the lumbar region: Present/ absent
   ii. Swelling over supra-pubic region: Present/ absent
   iii. Swelling over genitalia: Present/ absent

B. Palpation
   i. Tenderness: Present/ absent
   ii. Scrotal Edema: Present/ absent
   iii. Phimosis/ Paraphimosis: Present/ absent
   iv. Hydrocele/ Varicocele: Present/ absent
   v. Inguinal Hernia: Present/ absent
   vi. Testicular atrophy/ Hypertrophy: Present/ absent

C. Percussion
   i. Dullness over suprapubic area (Full bladder): Present/ absent
   ii. Shifting dullness (when over flanks): Present/ absent

D. Auscultation
   i. Renal artery bruit (over renal angle): Present/ absent

Teacher's Remarks (if any)

Signature of Teacher

Format –VIII

Imteḥān-e-Niẓām-e-Aṣabi (Examination of Nervous System)

A. Higher functions:

i. Level of Consciousness: Well Conscious and Alert / Drowsy/ Stupor/ Coma
ii. Emotional State (Normal /euphoric/ Depressed/ hostile)
iii. Orientation with time person and Place: well or ill oriented
iv. State of perception: Normal/ Illusion/ Delusion/ hallucination
v. Memory: Normal / Amnesia / Dementia
vi. Intelligence: Normal / Intelligent/ Genius/ Poor
vii. Speech: Normal/ Dysarthria/ Aphasia/ Dysphonia

B. Examination of Cranium and Spine: Normal/ Deformity (describe)

C. Assessment of functions of Cranial Nerves:

i. Olfactory: Smell sensation: Normal / Anosmia/ Hyposmia/ Parosmia
ii. Optic:
   a) Distant Visual acuity (on Snellen Chart):
   b) Near visual acuity (on Jaeger Chart):
   c) Field of vision
   d) Color vision

iii. Oculomotor, Trochlear and abducent:
   a) Squint: Absent/ Present
   b) Ptosis: Absent/ Present
   c) Pupillary reaction (Optic and Oculomotor): Normal or Abnormal

iv. Trigeminal:
   a) Motor function:
      a. Muscles of Mastication: Normal/ Poor
      b. Bite against resistance: Normal/ Poor
      c. Jaw protrusion against resistance: Normal/ Poor
      d. Lateral jaw movements against resistance: Normal/ Poor
   b) Sensory Function (sensation over the face): Normal/ Diminished
   c) Corneal reflex: Present/ Absent
   d) Jaw Jerk: Normal/ Exaggerated

v. Facial:

a) Motor functions:
   a. Frowning
      b. B/L Eyes closure
      c. Blowing the cheeks

d. Whistling
e. Showing teeth

b) Taste sensation of anterior 2/3 of tongue: Intact/ absent

vi. Vestibulocochlear:
a) Watch test
b) Rinne's test
c) Weber's test
d) Positional nystagmus

vii. Glossopharyngeal **and** Vagus:
a) Soft palate (movement on saying aáh): Central/ deviated
b) Pharyngeal or gag reflex: Absent/ Present
c) Taste sensation of posterior 1/3 of tongue: Intact/ absent

viii. Spinal Accessory:
a) Winging of Scapula: Absent/ Present
b) Flexion of Head against resistance: Normal/ Restricted

ix. Hypoglossal:
a) Protrusion of tongue: Normal/ Deviated

D. Examination of Motor functions:
i. Nutrition of Muscles (measurement of girth/ circumference: Normal/ hypertrophy/ atrophy
ii. Tone: Normal/ Hypertonic (Spastic)/ Hypotonic (Flaccid)
iii. Power: Grade 5 / Grade 4/ Grade 3/ Grade 2/ Grade 1/ Grade 0
iv. Coordination: Normal/ disturbed
v. Involuntary movements: Present/ absent

E. Examination of Sensory functions
i. Superficial Sensory functions (Perception of):
a) Pain: Normal/ Diminished/ Absent
b) Touch: Normal/ Diminished/ Absent
c) Temperature: Normal/ Diminished/ Absent
ii. Deep Sensory functions:
a) Vibration sense: Present/ absent
b) Pressure sense: Present/ absent
c) Joint sense (direction of joint movement):Present/ absent
iii. Cortical Sensory functions:
a) One-point Localization: Present/ absent
b) Two-point discrimination: Present/ absent
c) Stereognosis: Present/ absent
d) Graphesthesia: Present/ absent

F. Examination of Reflexes:

i. Superficial Reflexes:

a) Abdominal: Normal/ Diminished/ exaggerated
b) Cremasteric: Normal/ Diminished/ exaggerated
c) Planter response: Normal/ Diminished/ exaggerated

ii. Deep Reflexes:

a) Biceps jerk: Normal/ Diminished/ exaggerated
b) Triceps jerk: Normal/ Diminished/ exaggerated
c) Supinator jerk: Normal/ Diminished/ exaggerated
d) Knee jerk: Normal/ Diminished/ exaggerated
e) Ankle Jerk: Normal/ Diminished/ exaggerated
f) Clonus (Ankle clonus and patellar clonus): Normal/ Diminished/ exaggerated

G. Examination of Trophic changes:

i. Bedsore and Trophic Ulcer: Present/ absent
ii. Charcot Joint: Present/ absent

H. Examination of Cerebellar Functions:

i. Titubation
ii. Scanning Speech
iii. Pendular Knee jerk
iv. Intention tremor
v. Finger-nose Test
vi. Dysmetria
vii. Dyssynergia
viii. Dysdiadochokinesia
ix. Rebound phenomenon
x. Nystagmus
xi. Reeling gait

I. Psychiatric evaluation of Patient

J. Provisional Diagnosis

K. Required investigations

L. Proposed line of treatment (Usoole Ilaj)

Teacher's Remarks (if any)

Signature of Teacher

Format –IX

Imteḥān-e-Niẓām-e-Izām wa Mafāṣil (Examination of Musculoskeletal System)

A. Site of Swelling or Pain:

B. Tenderness: Mild/ Moderate/ Severe

C. Redness: Positive/ Negative

D. Local temperature (warmth) on palpation: Normal/ Raised

E. Crepitus: Positive/ Negative

F. Stiffness of joint: Positive/ Negative

G. Movement of Joints: Flexion/ Extension/ Normal/ Limited

H. Kyphosis, Lordosis, Scoliosis and Gibbus: Present/ absent

I. Provisional Diagnosis:

J. Required investigations

K. Proposed line of treatment (Usoole Ilaj)

Teacher's Remarks (if any)

Signature of Teacher