CLINICAL ACTIVITY BOOK

NAME OF THE INSTITUTE WITH LOGO

ROGA NIDAN EVAM VIKRITI VIGYAN
(AYURVEDA DIAGNOSTICS AND PATHOLOGY)

Name of the student:……

Registration number:……..

Academic year:……

University:……

NAME OF THE INSTITUTE WITH LOGO

ROGA NIDAN EVAM VIKRITI VIGYAN
(AYURVEDA DIAGNOSTICS AND PATHOLOGY)
(Subject code: AyUG-RN)

University course code:

DEPARTMENT OF ROGA NIDAN EVAM VIKRITI VIGYAN

(Name of the College)

(Approved by –National Commission for Indian System of Medicines, New Delhi &

Name of the University)

Name of the department

Batch- _____

Certificate

This is to certify that, Mr. / Ms. _____, Enrollment Number- _____ has satisfactorily completed the course of Practicals in (Subject Name) prescribed by the (Name of University) as a part of the Second Professional B.A.M.S. Course.

Examination Seat No.: _____

Date of Examination- _____

Sign. Of Internal Examiner-_____

Sign. Of External Examiner-_____

Sign. of Teacher

Sign. of H.O.D.

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Teacher’s signature

ROGA NIDAN EVAM VIKRITI VIGYAN ACTIVITY BOOK

SERIAL NO: 1 **CLINICAL NO: C 1.1 & 1.2**

1. Activity Name

Chief complaint & history of present illness

2. Activity Description:

Interact with patient and record their chief complaints and history of present illness. Write the narrative based on the instructions provided and conclude with your inference.

3. Materials and Equipment:

Case format, Stethoscope, Sphygmomanometer, Thermometer, Pen torch, Reflex hammer, Tuning fork, Measuring tape, Disposable tongue depressors, Cotton swabs, Disposable tissues or wipes, Rulers or Scales, Pins and Hand sanitizer.

4. Patient information:

Age:

Sex: M/ F/Others

Marital status:

Education:

Occupation:

Religion:

Socio-economic status:

Date of Consultation:

Out Patient Number:

Date of Admission:

In Patient Number:

Bed number:

Place of residence:

5. Pradhana Vedana with Kala prakarsha (Chief complaints with duration:) (List complaints succinctly using bullet points, avoid medical terminology, and if there are multiple symptoms, present them in chronological order.)

6. Vedana sammuchraya (History of present illness :) (Write the history of present illness along with duration in chronological order with components such as Onset, Location, Duration, Characteristic or nature, Relieving factors, Aggravating factors, Radiation, Timing or frequency, and severity in paragraph)

Write your inference on below mentioned points (As applicable to chief complaints and history of present illness):

Sl. No	Parameters to be assessed	Item observed in patient	Rationality
1	Dosha and dhatu vridhhi and kshaya		
2	Sama/ Nirama Dosha avastha		
3	Srotas involved		
4	System/ systems involved		
5	Any other		

Teacher's signature

ROGA NIDAN EVAM VIKRITI VIGYAN ACTIVITY BOOK

SERIAL NO: 2 **CLINICAL NO: C 2.1**

1. Activity Name

Past illness & treatment history

2. Activity Description:

Enquire and record about past illness and treatment history. Write your inference in the space provided.

3. Materials and Equipment:

Case format, Stethoscope, Sphygmomanometer, Thermometer, Pen torch, Reflex hammer, Tuning fork, Measuring tape, Disposable tongue depressors, Cotton swabs, Disposable tissues or wipes, Rulers or Scales, Pins and Hand sanitizer.

4. Patient information:

Age:

Sex: M/ F/Others

Marital status:

Education:

Occupation:

Religion:

Socio-economic status:

Date of Consultation:

Out Patient Number:

Date of Admission:

In Patient Number:

Bed number:

Place of residence:

5. Poorvavyadhi Vruttanta (History of Past illness) *(The signs and symptoms of respective system pathology can be enquired – Cardiovascular, Respiratory, Gastrointestinal, Neurological, Musculoskeletal, Endocrine, Immunological, Psychiatry, and Urogenital history in past illness, or any abnormalities such as diabetes mellitus, hypertension, bronchial asthma, Carcinoma, Myocardial infarction, Jaundice, Road Traffic Accident, Hospital admission, Blood transfusion, Surgeries, Childhood, etc including Immunization (e.g., Vaccinations, Booster Shots) can be mentioned in relation to the present complaints).

6. Chikitsa Vruttanta (Treatment history): **(Consider the following points while enquiring treatment history: Current Medications (with Dose/ Route of administration/ Chemical name/ Frequency/ Duration), Previous Medications (with Dose/ Route of administration/ Chemical name/ Frequency/ Duration), Medication Allergies or Intolerances, Date of Surgery, Type of Surgery, Surgeon/Provider Name, Outcome or Complications, Physical Therapy, Occupational Therapy, Speech Therapy, Rehabilitation Programs, Counselling or Psychotherapy, Injections or Infusions, Other Therapeutic Intervention, Dates of Hospitalizations, Reason for Hospitalization, Procedures Performed, Length of Stay, Discharge Summary, Herbal Supplements or Remedies, Acupuncture, Massage Therapy, Chiropractic Care, Ayurvedic Treatments, Other Complementary or Alternative Treatments, Treatment Adherence or Compliance, Treatment Modifications, Reasons for Modifications (e.g., Efficacy, Side Effects), Date of Consultation/Referral, Specialist/Consulting Provider Name, Reason for

Consultation/Referral, Recommendations or Findings from Consultation, Previously Attempted Alternative Treatments, Reasons for Discontinuation or Change of Alternative treatments, Outcome or Response to Previous Alternative Treatment, Patient's Response to Treatment, Treatment Efficacy or Effectiveness, and Side Effects or Adverse Reactions)

Additional space may be utilized below for detailed writeup for each section if required such as for multiple treatments or surgeries.

Clinical condition	****Treatment/ Surgery done or on-going** **(If Not Applicable mention NA)**	**Duration**	**Outcome & Remarks**

Mention Asatmya with reference to Aushadha (Drug allergy) (If any):

Write your inference in relation to the past/ present clinical condition:

Sl. No	**Parameters to be assessed**	**Item observed in past illness**	**Relation to the present illness**
1	Dosha – Anubandhya and Anubandha dosha		
2	Dushya involved		
3	Sroto dushti		
4	System involved		
5	Paraspara anubandha vyadhi		
6	Vyadhi sankara		

Teacher’s signature

ROGA NIDAN EVAM VIKRITI VIGYAN ACTIVITY BOOK

SERIAL NO: 3 **CLINICAL NO: C 3.1**

1. Activity Name

Family history with pedigree chart, social history, environmental history, seasonal history and occupational history

2. Activity Description:

Record and draw a pedigree chart reflecting the family history and write the summary. Write your inference in the space provided.

Interact and record social history, environmental, seasonal and occupational history of patient. Write your inference on possible impact of social history, environmental, seasonal and occupational history in reducing or aggravating or causing the current condition of the patient.

3. Materials and Equipment:

Case format, Stethoscope, Sphygmomanometer, Thermometer, Pen torch, Reflex hammer, Tuning fork, Measuring tape, Disposable tongue depressors, Cotton swabs, Disposable tissues or wipes, Rulers or Scales, Pins and Hand sanitizer.

4. Patient information:

Age:

Sex: M/ F/Others

Marital status:

Education:

Occupation:

Religion:

Socio-economic status:

Date of Consultation:

Out Patient Number:

Date of Admission:

In Patient Number:

Bed number:

Place of residence:

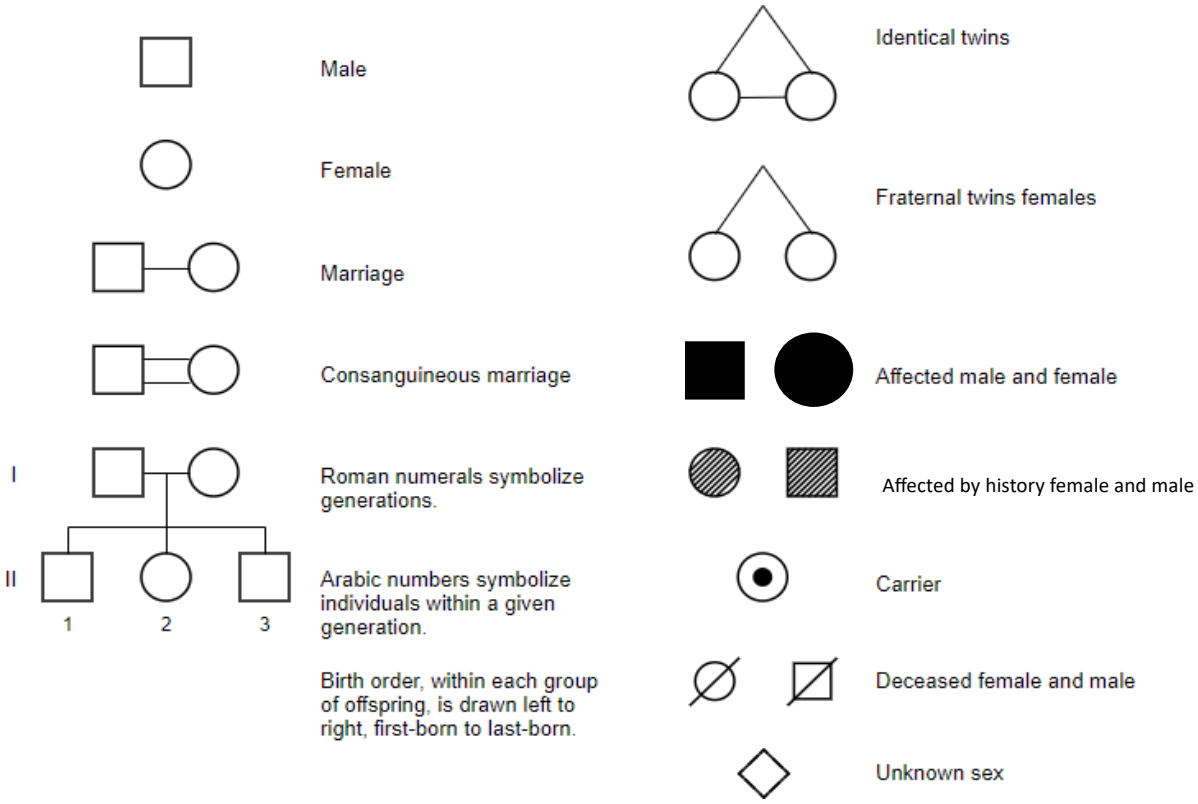
5. Kula vruttanta (Family history) Along with pedigree chart:

*Enquire following details: Genetic or Hereditary Conditions (Runs in family/ Identified genetic mutations or abnormalities), Any family member with similar complaints, Consanguineous marriage history, Ethnicity and Heritage (of patient and family), Environmental Factors (of patient and family), Cause of death of any family members, Confirmation and Source (Family history) and record in the respective section.

Family Member & Relation to patient	**Medical Condition (Relevant to family history – common and rare conditions)**	***Details of the medical condition**	**Write your inference with relevance to current condition of patient if applicable**

Pedigree chart (Draw):

Symbols for drawing Pedigree chart:



[Image Source: Visual Paradigm Online]

Draw the Pedigree chart for the patient:

Write your inference on below mentioned points:

Sl. No	Parameters to be assessed	Observations in family member	Any relation to the current illness
1	Bija dushti (Specify Bija, Bija bhaga, Bija bhaga avayava dushti if possible)	Yes/ No	
2	Adibala (Hereditary)	Yes/ No	
3	Janmabala (Congenital)	Yes/ No	

6. Samajika Vruttanta (Social history):

(Enquire the following details in respective sessions – **1.** Patient's current living arrangements, including whether they live alone, with family, in any health care centres, or in other housing situations **2.** Single, married, divorced, separated, or widowed **3.** Patient's educational background, and any vocational training or higher education degrees **4.** Patient's social support system, including family, friends, and community resources that play a role in their life, any significant relationships and sources of support **5.** Patient's history of substance use, including alcohol, tobacco, and recreational drugs along with the type, frequency, and duration of substance use, as well as any history of substance abuse or addiction **6.** When appropriate and relevant, report on the patient's sexual history, including sexual orientation, sexual activity, and any history of sexually transmitted infections **7.** Patient's cultural and religious affiliations, beliefs, and practices that may be relevant to their healthcare. Consider how these factors may influence their health beliefs and healthcare decision-making **8.** Highlight the patient's hobbies, interests, and recreational activities that contribute to their social engagement and well-being. This may include sports, arts, volunteering, or other leisure activities **9.** Patient's financial status, including their employment income,

insurance coverage, and any financial challenges that may impact their access to healthcare **10.** Significant life events, social stressors, or challenges that the patient is facing, such as recent loss, family conflicts, or housing instability **11.** Any additional social factors that are relevant to the patient's health and well-being, such as immigration status, military service, or involvement in the criminal justice system)

Areas to be enquired (Refer the above paragraph)	**Observations**	**Relevance in terms of shareerika dosha and manasika bhava**
[1]Living Situation		
[2]Marital/Relationship Status		
[3]Education		
[4]Social Support Network		
[5]Substance Use History		
[6]Sexual History		
[7]Cultural and Religious Background		
[8]Hobbies and Recreational Activities		
[9]Financial Status		
[10]Social Stressors and Challenges		
[11]Other Relevant Social Factors		

7. Desha (Environmental history):

Specify jaata and vyadita desha: Jaata - Jangala/ Anupa/ Sadharana;
Vyadita - Jangala/ Anupa/ Sadharana

Areas to be enquired	**Observations**	**Relevance in terms of shareerika dosha and manasika bhava**

Climate and geographical location of Residential area		
Duration of stay in the residential area with location		
Duration of stay (If shifted from previous residence to a new location - mention details)		
Travel history and exposures related to travel		

8. Kala (Seasonal): (Describe below any aggravation of complaints with relevance to the kala or season):

9. Occupational history: *(Enquire regarding current occupation, job duration, work environment, hazards and exposures, protective measures, work schedule, previous occupations, occupational injuries, psychosocial factors, occupational health screenings):

***Occupational history**	***Write Your observation**	**Relevance to shareerika dosha and manasika bhava**
Physical environment		
Psychological environment		

Teacher's signature

ROGA NIDAN EVAM VIKRITI VIGYAN ACTIVITY BOOK

SERIAL NO: 4 **CLINICAL NO: C 4.1**

1. Activity Name

Personal history

2. Activity Description:

Enquire and record about personal history. Write your inference on possible impact of personal history in aggravating or causing the current condition of the patient.

3. Materials and Equipment:

Case format, Stethoscope, Sphygmomanometer, Thermometer, Pen torch, Reflex hammer, Tuning fork, Measuring tape, Disposable tongue depressors, Cotton swabs, Disposable tissues or wipes, Rulers or Scales, Pins and Hand sanitizer.

4. Patient information:

Age:

Sex: M/ F/Others

Marital status:

Education:

Occupation:

Religion:

Socio-economic status:

Date of Consultation:

Out Patient Number:

Date of Admission:

In Patient Number:

Bed number:

Place of residence:

5. Vaiyaktika Vruttanta (Personal history):

Ahara, Agni, Koshta, Mala – Pureesha/ Bowel:

Ahara:

Tick appropriate:

Ahara matra or Abhyavaharana shakti – Poorvakaleena i.e Heena/ Madhyama/ Pravara

Ahara matra or Abhyavaharana shakti – Adyatana i.e Heena/ Madhyama/ Pravara

Most commonly consumed food items	**Identify the predominant Rasa, Guna and classify in terms of satvika, rajasika, tamasa**	**Write your inference regarding influence on Agni, Dosha (Manasika and Shareerika), and Dushya**

Ahara vidhi: Regular/ Irregular; Interval between two consumptions……Hrs; Frequency of meals per day……..

Upavasa: Engaging/ Not engaging. If engaging mention pattern of fasting……..

Mention Asatmya with reference to Aahaara (If any):

Agni (*Enquire the mentioned points to the patient to infer regarding the Agni bheda - Teekshna/ Manda/ Vishama/ Sama agni):

Pattern of Digestion	Tick the type of agni
Even small quantity of regular meal (easily digestible) may take longer time to digest & reduced appetite for the next scheduled meal.	☐ Mandagni
Regular serving of meal consumed on regular intervals gets digested normally and good appetite for next scheduled meal.	☐ Samagni
Regular serving size of regular meal gets digested quickly with frequent hunger pangs & making the person to eat at frequent intervals before next meal scheduled time. Even heavy meals get digested easily before the next scheduled meal time.	☐ Teekshnagni
Irregular phase of digestion & indigestion which may also be associated with regular bowel movement and constipation.	☐ Vishamagni

Mala pravrutti – Pureesha/ Bowel:

Parameters to be enquired	Write your observation	Write your inference
Frequency (Per day)	……..Per day.	

Consistency	Ati grathita (Knotty or hard stool)/ Ati drava (Watery)/ Picchila (Slimy)/ Any other…….	Sama/ Nirama (Also mention predominance of dosha)
Colour & Appearance	Tila pishta nibha (Pale or Clay coloured)/ Peeta (Yellowish)/ Shyava (Blackish)/ Rakta (Reddish)/ Harita (Greenish)/ Any other…..	
Pravahika (With tenesmus)	Yes/ No	
Evacuation	Complete/ Incomplete (Kricchra pureesha, Alpa pureesha, etc.)	
Faecal incontinence	Present/ Absent	
Any other complaints	Sa shoola/ Any other….	

Mutra pravrutti – Micturition:

Urine characteristics	**Write your observation**	**Write your inference on dosha involved**
Frequency at day		
Frequency at night		
Stream	Forceful/ Weak/ Dribbling/ Split/ Spraying/ Narrow	
Colour	Pale yellow/ Dark yellow/ Amber/ Brown/ Pink or red/ Orange	
Burning sensation	Yes/ No	
LUTS*	Yes/ No	
Any other		

*LUTS – Lower Urinary Tract symptoms: Voiding or obstructive symptoms: Hesitancy, Poor and/or intermittent stream, Straining,

Prolonged micturition, Feeling of incomplete bladder emptying, Dribbling, Any other. Storage or irritative symptoms: Frequency, Urgency, Urge incontinence, Nocturia, Any other.

Koshta (Mridu/ Madhyama/ Krura):

Influence of mentioned items on koshta observed and other features in the patient	**Tick the type of koshta**
Has regular bowel movements, typically once or twice daily. Stools are either semi-formed or fully formed, making defecation easy and requiring less time. Experiences satisfaction after bowel movements. Weak laxatives and the consumption of Ikshu, Ksheera, Payasa, Sarpi, Draksha, and Ushna jala can easily lead to loose stools.	☐ Mridu koshta
Has daily bowel movements, passing formed stools with minimal stress and taking a slightly longer time compared to a mridu koshta. Experiences satisfaction after defecation and rarely encounters loose stools or hard stools.	☐ Madhyama koshta
Irregular bowel movements with infrequent stool passage. Stools are hard and dry, necessitating straining and an extended time for defecation. Bowel clearance is unsatisfactory, and hard stool is more prevalent than loose stools. Generally requires laxatives to clear stools.	☐ Krura koshta

Work, Nidra, Vyasana:

Nature of work	Write your observation and inference	Inference for shareerika dosha and manasika dosha
Type of karma (Work)	Shareerika/ Manasika/ Vachika	
*Nature of work (Refer below)		
Timing/ Duration of work		
If shifting duties (Specify pattern)	Morning/ Evening/ Night/ Any other….	
Sedentary	Yes/ No	
Exertional	Yes/ No; If Yes - Physically/ Mentally/ Both	
Performs beyond or less than Ardha shakti (Shareerika)**Refer below	More/ Less	

*(Enquire for Work: Manual Labour – Lifting, Carrying, Pushing, Pulling, Grasping, Manoeuvring heavy objects; Repetitive Movements - Repetitive lifting, Continuous bending, Prolonged standing, Frequent kneeling; Fine Motor Skills - Precision tasks, Small object manipulation, Detailed handwork; Sedentary Work - Desk work, Computer-based tasks, Administrative duties; Outdoor Work - Exposure to weather conditions, Physical activities in varying climates, Fieldwork; Heavy Machinery Operation - Operating equipment, Machinery handling, Vehicle driving; Construction Work - Building structures, Demolition work, Carpentry; Healthcare Professions - Patient care, Medical procedures, Surgical interventions; Agricultural Work - Farming activities, Animal care, Crop harvesting; Service Industry - Waitstaff duties, Customer service roles, Retail tasks;

Athletic or Sports Activities - Training sessions, Competitive sports, Coaching responsibilities; Educational Field - Teaching tasks, Classroom activities, Lab work)

** *Kaksha lalaata nasaasu hasta paadaadati sandhishu prasvedan mukha shosha. Hruda sthaana sthito vaayu yadha vaktram prapadyate.*

Mention Asatmya with reference to Vihaara (If any):

Nidra:

Nidra	**Write your observation and inference**	**Inference for shareerika dosha and manasika dosha**
Status of nidra	Normal (Sufficient sleep and Freshness after getting up or not)/ Excess/ Disturbed*	
*If disturbed -	Difficulty in getting the sleep/ Difficulty in maintaining the sleep/ Early morning awakening	
Duration in hrs per day and night		
Divasavpna	Present/ Absent (If present specify duration)	
Ratri jagarana	Present/ Absent (If present specify duration)	

Vyasana:

Addictions/ Habits	Duration & Quantity	Dependence Yes/ No	Inference for shareerika dosha and manasika dosha
Smoking			
Alcohol			
Tobacco chewing			
Screen time			
Any Others			

Raja pravrutti – Menstrual history:

Menstruation and Menstrual cycle characteristics	Write your observation	Inference for shareerika dosha
Raja pravrutti - Regular/ Irregular		
Days of flow		
Duration of cycle		
Nature of flow - Quantity (E.g. No. of Pads, or menstrual cup, etc.)		
Clots, odour, etc.		
Any other complaints or observation		

Obstetric History (Mention G P L A D with details of delivery and complications, if any):

G - Gravida, P - Parity, L - Living Child, A – Abortion D – Death after live birth*(**Furnish information regarding GPLAD below as subscript** Eg: G = Gravida (Times conceived) P = Para (Number of pregnancies crossed viability) L= Live (Number of live births) A =

Abortion (Number of abortions) D = Death after live birth (Number of deaths after live birth).

G_3 P_1 $L_1A_2D_0$ = G_3 - Patient got pregnant 3 times out of which P_1 - 1 pregnancy crossed Viability age, L_1 - one pregnancy delivered live baby and A_2 - out of 3 pregnancies 2 abortions happened and D_0 - no death after live birth.

***G P L A D** (Write as sub script here. Ex - G_3 P_1 $L_1A_2D_0$)

Delivery (First/ Second/ etc.)	**Mode of delivery** (Normal vaginal/ Forceps/ LSCS)	**Post-partum complication** (Yes/ No; If Yes elaborate)

Write inference based on your observation:

Manasika bhava (Emotional makeup): *(Write the manasika bhava experienced by the patient such as Shoka, Chinta, Bhaya, Dvesha, Krodha, Lobha, Mada, or any other)

***Manasika bhava (Emotion) experienced by the patient**	**Write your inference (Regarding manasika dosha affected)**

Vegadharana: Present/ Absent (If present, specify with duration and frequency)

Any other relevant information to be furnished in personal history:

Teacher's signature

ROGA NIDAN EVAM VIKRITI VIGYAN ACTIVITY BOOK

SERIAL NO: 5 **CLINICAL NO: C 5.1 & 5.2**

1. Activity Name

A comprehensive general physical examination

2. Activity Description:

Perform and record general physical examination of patient, and write your inference in the space provided.

3. Materials and Equipment:

Case format, Stethoscope, Sphygmomanometer, Thermometer, Pen torch, Reflex hammer, Tuning fork, Measuring tape, Disposable tongue depressors, Cotton swabs, Disposable tissues or wipes, Rulers or Scales, Pins and Hand sanitizer.

4. Patient information:

Age:

Sex: M/ F/Others

Marital status:

Education:

Occupation:

Religion:

Socio-economic status:

Date of Consultation:

Out Patient Number:

Date of Admission:

In Patient Number:

Bed number:

Place of residence:

5. General physical examination:

Sangya jnana (Consciousness):

Conduct a subjective evaluation of consciousness, considering reporting in Ayurveda as Moha, Murcha, Mada, Tandra, Mada, Sanyasa, Tama pravesha, Nisangya, as well as subjective descriptors such as Lethargy, Drowsy, Stupor, Obtundation, Coma, etc.

Write the observations on Sangya jnana (Consciousness) – Subjective assessment	**Write your inference**

Vitals:

Pulse examination/ Nadi pareeksha:

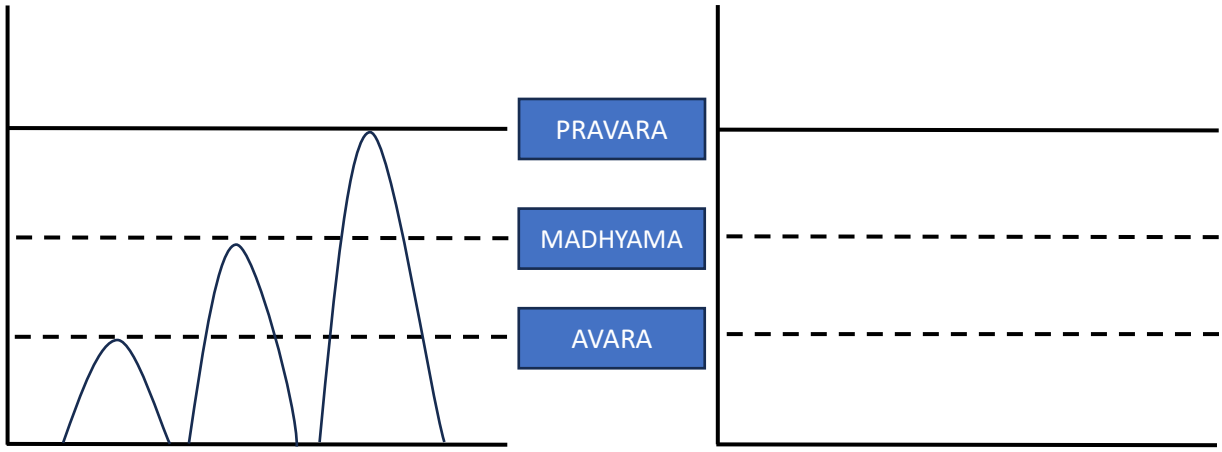
Site:

Parameters to be examined	**Write the observations on Pulse**	**Write your inference (Regarding dosha involved)**
Palpable	Yes/ No	
Rate	……. Per minute (Tachycardia/ Bradycardia)	
Rhythm	Regular/ Irregular (If irregular – Regularly	

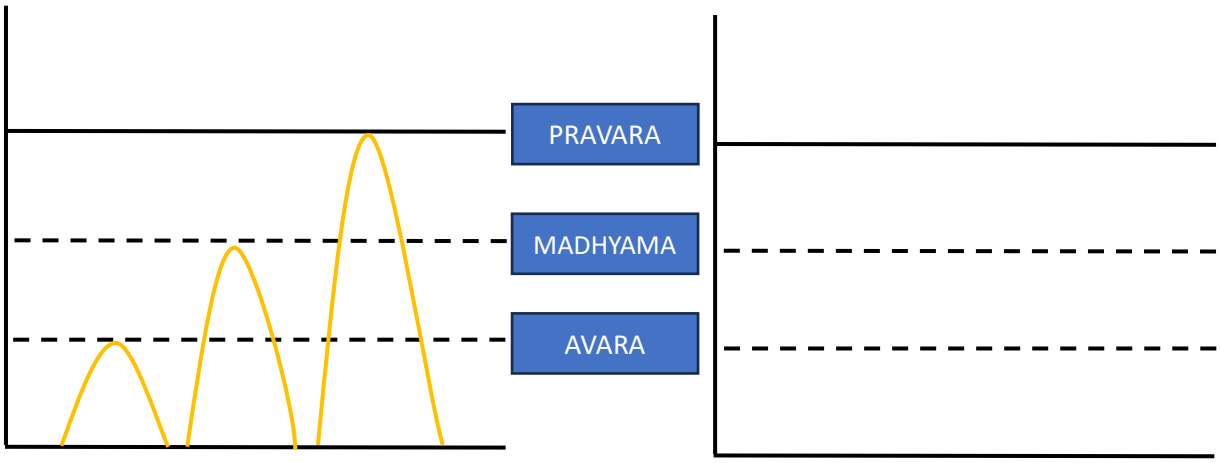
	irregular, Irregularly irregular)	
Character	Water-Hammer Pulse (Corrigan's Pulse)/ Pulsus Parvus et Tardus/ Any other……..	

Illustrate your observations on the blank graph, following the example provided on the left side for pravara, madhyama, or avara. The left-side graphs serve as visual guides (Black line represents Vata, Green represents Pitta, Blue represents Kapha) for creating graphs on the right, considering the amplitude and volume of the felt pulse. Dedicate one graph for each finger—Index, Middle, and Ring finger. The final graph is for collective observations, providing a graphical representation based on dosha-wise analysis:

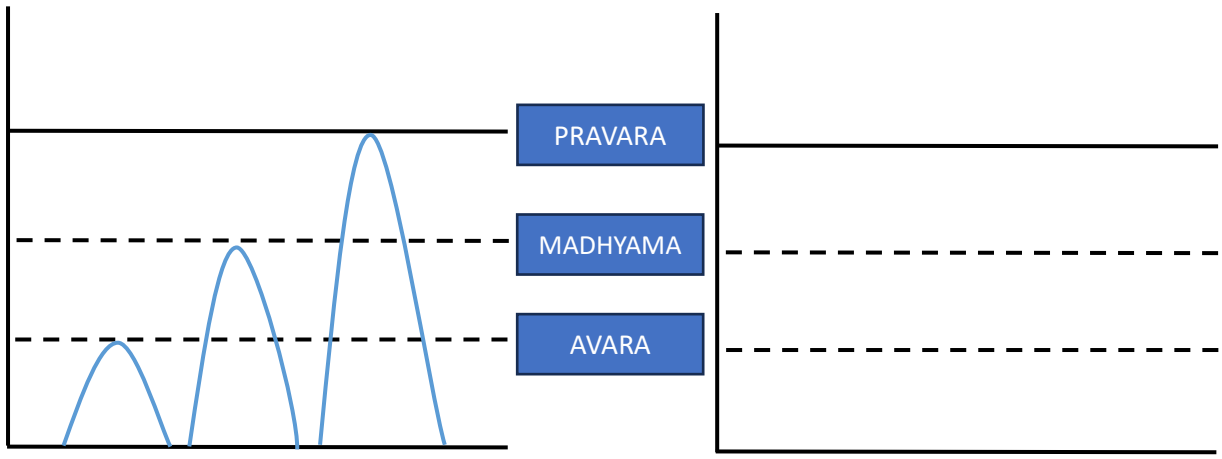
Example **Observation**



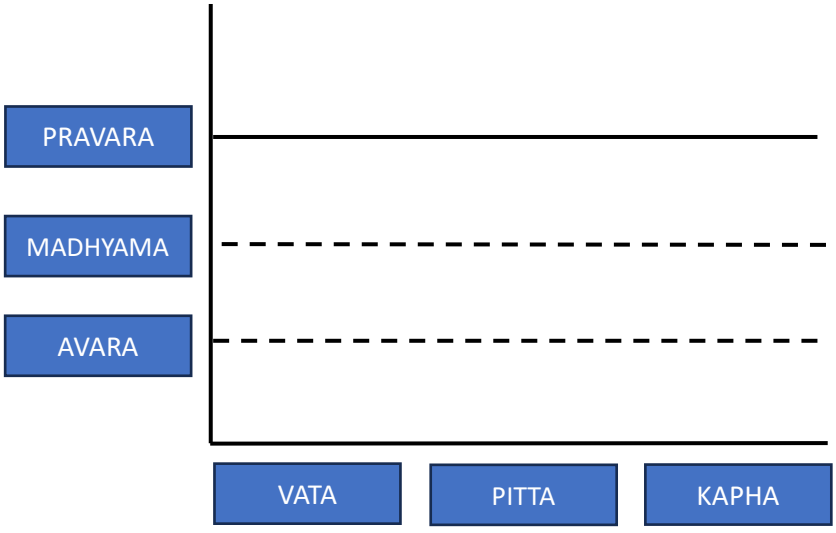
Index finger



Middle finger



Ring finger



Collective observation

Write your inference on predominant dosha associated:

Heart rate: *(Furnish details on rate and rhythm)

Parameters to be assessed	*Write the observations	Inference
Heart rate		
Rhythm		

Blood pressure:

Patient position	Write the observations on Blood pressure (Palpatory and Auscultatory method)	Write your inference (Normotensive/ Hypertensive/ Hypotensive)
Supine		
Sitting		
Standing		

Temperature:

Site of measurement	Time of measurement	Temperature in Celsius or Fahrenheit	Write your inference (Low grade, Moderate grade, High grade)

Respiratory rate:

Write the observations on Respiratory rate (per minute)	Write your inference (Tachypnoea, Bradypnea)

Observe for Pallor, Icterus and Cyanosis. Write your inference below:

Pallor (Pandutvam):

Site	Pallor (Yes/No)	Write your inference
Palpebral conjunctiva		
Lips		
Oral mucosa		
Tongue		
Face		
Skin (Palm/ Sole/ General)		
Nails		

Icterus (Peeta mukha, netra, tvak):

Site	Icterus (Yes/No)	Write your inference
Sclera		
Oral cavity		
Sublingual mucosa		
Skin (Palm/ Sole/ General)		

Nails		

Cyanosis (Central and Peripheral) (Shyava varna):

Site	Cyanosis (Yes/No)	Write your inference
Nose tip (Central)		
Lips (Central)		
Tongue (Central)		
Finger/ Toe tip (Peripheral)		
Nails (Peripheral)		
Peripheral parts of body (Peripheral)		

Nakha pareeksha (Examination of nail & nail bed):

Parameters to be observed	Write your observations and inference (Eg: Rough nails indicate rookshata, Shiny nails indicate snigdhata, etc.)
Nail clubbing (With grade)	
Spooning of nail (Koilonychia)	
Brittleness and crumbling	
Colour of the nail bed	
Capillary refill of nail bed	
Tenderness of nail bed	

Shareera pramana, Akriti, Samhanana, Sara and other features (Height, Weight, Body Mass Index, Built, Nutrient deficiency):

*Use thumb width in centimetres as anguli pramana (Charaka). Measure width of thumb in centimetres using standard measuring tape. Measure height in centimetres using standard measuring tape. Convert the height in anguli pramana by using the following formula:

Height (in cm)/ Width of thumb (in cm) = …….. Anguli pramana of height

Normal height of an individual is 84 anguli. <84 anguli is hrsva. >84 anguli is dheerga.

For example height of an individual is 168 cm and width of thumb is 1.9 cm, so his height is 168/1.9 = 88 Anguli pramana (Dheerga)

Parameter to be assessed	Observation	Inference
Shareera pramana		
*Height (Refer above)		Deergha/ Hrsva/ Prakruta
Weight (Weight in Kilograms		Ati sthoulya/ Atikrisha
Body Mass Index (Refer BMI Chart below)* (BMI) calculation. Ati sthoulya/ Atikrisha	Formula: Weight (kg) / Height $(m)^2$	Ati sthoulya/ Atikrisha
Akriti - Built - Endomorphic, ectomorphic, and mesomorphic		Ati sthoulya/ Atikrisha

Nourishment status		
Muscle bulk (Left mid upper arm circumference in centimetres)		Over nourished/ Well-nourished/ Under nourished
Subcutaneous fat thickness (Triceps skin fold thickness of mid arm in millimetres)		
Macronutrient deficiency (Protein/ Carbohydrate/ Fat)	Absent/ Present (If present specify)	
Micronutrient (Vitamin & Mineral deficiency)	Absent/ Present (If present specify)	

***BMI Chart:**

WHO CLASSIFICATION OF WEIGHT STATUS	
WEIGHT STATUS	**BODY MASS INDEX (BMI), kg/m^2**
Underweight	<18.5
Normal range	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥ 30
Obese class I	30.0 – 34.9
Obese class II	35.0 – 39.9
Obese class III	≥ 40

[Image source: Quizlet Flash cards]

Sparsha pareeksha:

Oedema (Shotha):

* Examine regions such as Face, Hands, Legs, Sacral, or any other specified areas, and record distinct observations in separate rows, indicating the side (Right/ Left) for each.

*Site of oedema examined (Refer above)	Observation Darshana – Inspection	Observation Sparshana – Palpation	Write your inference in terms of dosha and dushya
	Visible swelling – Present/ Absent Symmetry – Symmetrical/ Asymmetrical Skin colour – Normal/ Altered (If altered mention)…….	Consistency – Firm/ Soft Temperature – Normal/ Altered (If altered mention) Tenderness – Present/ Absent Pitting/ Non – pitting oedema Circumference ……..	

Features to be observed for shotha in patient	Tick the type of shotha
The migrating pitting oedema, primarily localized in the lower extremities, amplifies throughout the day (diva bali), yet significantly diminishes by night.	☐ Vataja
The non-pitting or slowly pitting oedema, predominantly affecting the upper body, notably the face, escalates during the night (ratri bali), reaching its peak visibility in the early morning	☐ Kaphaja

hours, and gradually diminishes as the day progresses.	
The swiftly advancing localized edema exhibits diverse hues like brown, reddish, coppery red, or black. It presents warmth, tenderness upon touch, and intense burning sensations. Occasionally, systemic indications hint at potential suppuration.	☐ Pittaja

Lymphadenopathy:

*Examine various sites, including the neck, underarms, and groins, for nodes such as submental, submandibular, pre-auricular, post-auricular, occipital, deep and superficial cervical chain, axillary, inguinal. Record positive findings in separate rows, specifying the side (Right/ Left) of involvement if observed.

***Site/ Lymph node examined (Refer above)**	**** Write the observations on Lymph node Examination –** **[1]Darshana – Inspection;**	**** Write the observations on Lymph node Examination – [2]Sparshana – Palpation**	**Write your inference (Include comments on involvement of drainage areas of respective node if involved)**
	Visible swelling – Present/ Absent Symmetry – Symmetrical/ Asymmetrical	Tenderness – Present/ Absent Consistency – Firm/ Soft/ Rubbery/ Hard Size (Measure using finger breadth or measuring tape or callipers) –	

		Mobility – Freely movable/ Fixed	

Shabdha pareeksha – Examining voice and speech of patient:

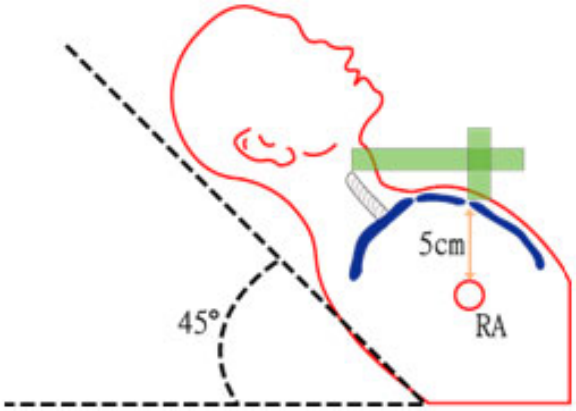
Parameter	Observation	Inference
Voice	Prakruta/ Vaikruta	
Speech	Prakruta/ Vaikruta	
Dosha assessment (Kapha - Guru; Pitta - Sphuta (broken, split); Vata - Khara, Parusha)		

Jihwa pareeksha (Tongue examination):

*(Varna – Pandu, Rakta, Haridra, Harita, Krishna, Neela, Shweta; Pramana – Tanu, Sama, Sandra; Upalepa; Chalana)

Parameters	*Write the observations on Jihwa	Write your inference
Colour		
Contour and size		
Coating		
Appearance		
Dosha assessment (Vata - Khara sparsha, sphutita, Sheeta; Pitta - Raktashyama varna; Kapha - Shweta, Ati picchila)		

Jugular Venous Pressure (JVP): Present/ Absent (If present mention in centimetres)



[Image source: Quizlet Flash cards]

Mention the height of JVP on diagram above sternum

Any other relevant information to be furnished in general physical examination:

Teacher's signature

ROGA NIDAN EVAM VIKRITI VIGYAN ACTIVITY BOOK

SERIAL NO: 6 **CLINICAL NO: C 6.1 & 6.3**

1. Activity Name

Respiratory system examination

2. Activity Description:

Perform and record respiratory system examination of patient. Write your observations and interpretation on possible conditions or diseases the patient is suffering from.

3. Materials and Equipment:

Case format, Stethoscope, Sphygmomanometer, Thermometer, Pen torch, Reflex hammer, Tuning fork, Measuring tape, Disposable tongue depressors/ Stainless steel tongue depressor, Cotton swabs, Disposable tissues or wipes, Rulers or Scales, Peak flow meter, Pins and Hand sanitizer.

4. Patient information:

Age:

Sex: M/ F/Others

Marital status:

Education:

Occupation:

Religion:

Socio-economic status:

Date of Consultation:

Out Patient Number:

Date of Admission:

In Patient Number:

Bed number:

Place of residence:

5. Respiratory system examination:

Prashna pareeksha – Short history (Including upashaya anupashaya) – Relevant to the patient:

Darshana pareeksha - Inspection:

*Perform Nasa pareeksha –

Upper respiratory tract – **External appearance** like structure of nose, shape, symmetry, deformities, lesions, swellings or any other changes on skin), **nasal cavity** (mucosal colour, swelling, discharge and any other abnormalities), septum (deviation), turbinate (hypertrophy), nasal polyps, nasal discharge - nasa srava (colour) and record the findings with inference below:

*Site of examination	*Observations	Inference

*Observe Mukha/ Taalu/ Gala pareeksha - Oral cavity and throat (oral cavity, tonsils, uvula and pharynx, post nasal drip) and record the findings with inference below:

*Site of examination	*Observations	Inference

Shape of chest: Normal/ Abnormal (Barrel shaped) ……..

Antero-posterior diameter of Chest:……
Transverse diameter of Chest:……

[1]Perform Ura pareeksha (*Kubjatva – Yaduktam hrudayam yadi va prushtam unnatam kramasha sa ruk – Hrudayam unnatam* – pectus carinatum or pigeon shaped chest and Pectus excavatum or funnel shaped chest; *Prushtam unnatam* – Kyphosis, Lordosis, Scoliosis)

Identify whether these deformities are there Sahaja (since birth) or Jataja (acquired), see for [2]Harrison's sulcus, symmetry of the chest, [3]Trail's sign, and [4]Apex beat:

[1]Mention shape of chest (Refer above)	Sahaja/ Jataja	Inference

[2]Harrison's sulcus (Present/ Absent)	Inference

[3]Trail's sign (Present/ Absent)	Inference

[4]Apex beat (Observed/ Not observed) If observed approximate location	Inference

Symmetry of chest: Symmetrical/ Asymmetrical

Respiratory movements:

*Observe for respiratory movements – different areas of chest (Supraclavicular, Infraclavicular, Mammary, Infra mammary, Axillary, Supra scapular, Inter scapular and Infra scapular areas)

Respiratory movements: Equal/ Diminished ----- Right/ Left

Movement of accessory respiratory muscle:

*Observe for **movement of accessory respiratory muscles** - sternocleidomastoid muscle, scalene muscles, trapezius muscle, and abdominal muscles and record the findings with inference below **(Yes/ No)**

If Yes provide details regarding **Notching of suprasternal and supra clavicular area, Indrawing of intercostal muscles, and Type of breathing (Thoraco-abdominal breathing, and Abdomino-thoracic breathing):

*Name of Accessory respiratory muscle	*Movement Present/ Absent	Inference (**Mention the outcome of laboured breathing)

Nishteevana (Examination of sputum):

Mention features of nishteevana	Observation	Inference
Character - Shushka kapha, Sa kapha (If kapha present - Tanu Kapha, Ghana Kapha, Alpa kapha) **Colour -** Peeta nishteevana, Raktayukta kapha, Harita kapha, Puyopama kapha **Consistency -** Alpatam vrajet (Non – sticky and little), Krcchran muktva (thick tenacious sputum), Snigdha kapha **Odour -** Durgandha yukta kapha (As per patient's statement) **Special observations -** Poorva kaasate sushkam tat shteevate sa shonitam, Shleshma aavruta mukha srota kapha (frothy sputum) **Any other -**		

Write your inference on below mentioned points:

Sl. No	Parameters to be assessed	Item observed in patient	Rationality
1	Dosha – Anubandhya and Anubandha dosha		
2	Sama/ Nirama Dosha avastha		

Sparshana pareeksha of Kantha and Uras - Palpation:

Position of trachea: Central/ Deviated ----- Right/ Left.....
Expansion of the chest -------- cms
Movement of the chest: Equal/ Diminished
Tenderness: Absent/ Present (If present mention the location)
Tactile vocal fremitus: Present/ Absent

Shabdha prakshobha pareeksha - Percussion:

Conduct percussion in the intercostal space at Supraclavicular, Infraclavicular, Mammary, Infra mammary, Axillary, Supra scapular, Inter scapular and Infra scapular areas for various percussion notes such as Resonant, Hyper resonant, Tympanic, Dull, Stony dull note and mark on given diagram below with respective observation and inference.

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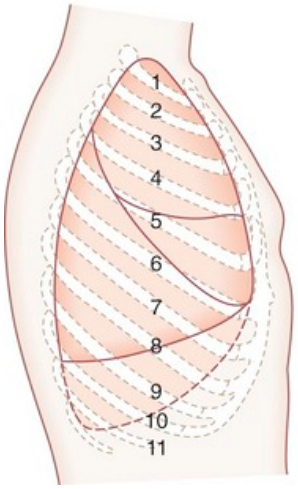

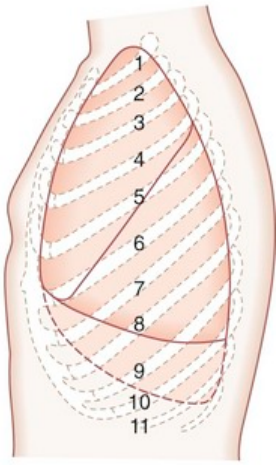

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Shrotrendriyataha pareeksha - Auscultation:

Breath sounds (Specify the particular area corresponding to ribs or lobes of the lungs, and indicate the side of examination when documenting observations):

Breath Sounds	Audible / Not Audible	Unilateral/Bilateral (Specify area)	Observation with interpretation
Vesicular			
Bronchial			
Bronchovesicular			

#Click here to listen for bronchial, vesicular and broncho vesicular sounds:!https://www.youtube.com/watch?v=JFWMJGtmG5E

Added sounds:

Added Sounds	Audible/ Not Audible	Unilateral/ Bilateral (Specify area)	Inspiratory (Early/ Late)	Expiratory	Both	Observation with interpretation
Crackle/ Crepitation						

#Click here to listen for crackle or crepitation:
https://www.youtube.com/watch?v=AbfsN1YgeSw

Added Sounds	Audible/ Not Audible	Unilateral/ Bilateral	Inspiratory/ Expiratory/ both	Monophonic/ Polyphonic	Fixed/ Random	Observation with interpretation
Wheeze/ Ronchi						

#Click here to listen for wheeze or rhonchi:!
https://www.youtube.com/watch?v=aMMlclpBNpg
https://www.youtube.com/watch?v=7cIEXfqnYRQ

Added Sounds	Audible/ Not Audible	Unilateral/ Bilateral	Observation with interpretation

Pleural rub			

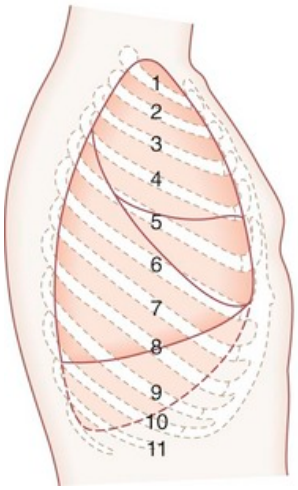
#Click here to listen for pleural rub:!
https://www.youtube.com/watch?v=yq0Z3TgGWS4

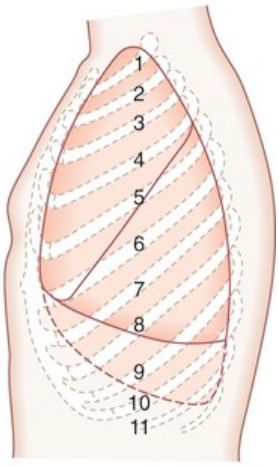
Voice sounds:

Voice Sounds	Audible/ Not Audible	Unilateral/ Bilateral	Observation with interpretation
Bronchophony			
Aegophony			
Whispering pectoriloquy			

#Link for bronchophony, aegophony, whispering pectoriloquy:
https://www.youtube.com/watch?v=wb15Dex0EFI
https://www.youtube.com/watch?v=E6VC1esEPcY

Provide a summarized overview of the information pertaining to breath sounds in the diagram presented below:





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Conduct a comprehensive assessment by considering history (including upashaya anupashaya), a thorough physical examination, systemic examination, and relevant investigations. Additionally, perform a differential diagnosis (sapeksha and vyavachedaka nidana) based on the gathered data.

6. Summarize the observations:

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ROGA NIDAN EVAM VIKRITI VIGYAN ACTIVITY BOOK

SERIAL NO: 6 **CLINICAL NO: C 6.2 & 6.4**

1. Activity Name

Cardiovascular system examination

2. Activity Description:

Perform and record cardiovascular system examination of patient. Write your observations and interpretation on possible condition the patient is suffering from.

3. Materials and Equipment:

Case format, Stethoscope, Sphygmomanometer, Thermometer, Pen torch, Measuring tape, Disposable tongue depressors, Cotton swabs, Disposable tissues or wipes, Rulers or Scales, Peak flow meter and Hand sanitizer.

4. Patient information:

Age:

Sex: M/ F/Others

Marital status:

Education:

Occupation:

Religion:

Socio-economic status:

Date of Consultation:

Out Patient Number:

Date of Admission:

In Patient Number:

Bed number:

Place of residence:

5. Cardiovascular system examination:

Prashna pareeksha – Short history (Including upashaya anupashaya) – Relevant to the patient:

Darshana Pareeksha - Inspection:

Features to be observed	Observation	Inference
Precordial bulge		
Location of apex impulse		
Double apical beat		
Neck pulsation		

Sparshanendriyataha pareeksha - Palpation:

Feature to be examined	Observation	Inference
Location of apex beat	Not palpable/ Palpable (If palpable mention the Intercostal space)	
Thrills	Present/ Absent	

Shabdha prakshobha pareeksha - Percussion:

Shrotrendriyataha pareeksha - Auscultation:

Feature to be examined with observation	Inference
Heart Rate & Rhythm	
Intensity of S1	
Intensity of S2	
Character of S1: ..... split..... (Physiological/ Pathological)	
Character of S2: ..... split..... (Physiological/ Pathological – Wide, Wide fixed, Paradoxical)	
S3 and S4: Present/Absent	
Gallop: Present/Absent	

#Click here to listen for heart sound (S1 S2 and Split/ S3 and S4, Gallop): https://www.youtube.com/watch?v=eF-6Cm8amIM
https://www.youtube.com/watch?v=7J72wFtBdU4
https://www.youtube.com/watch?v=o8eqYHCy7dw

Added sounds to be examined with observation (Specify area)	Inference		
Ejection clicks: Present/Absent			
Opening snaps: Present/Absent			
Murmurs (Daraa – Dara darika): *Present/Absent *(If present answer below)	Intensity	Pitch	Manoeuvres
*Systolic murmur - Pan systolic, Long systolic/Early systolic, Mid systolic, Late systolic: Present/ Absent			
*Diastolic murmur - Early diastolic, Mid diastolic, Pre systolic			

Continuous murmur: Present/ Absent	
Carey Coombs murmur: Present/ Absent	
Austin Flint murmur: Present/ Absent	

#Click here to listen for cardiac murmur with details, Carey Coombs murmur and Austin Flint murmur:
https://www.youtube.com/watch?v=IrWEAucHoA0
https://www.youtube.com/watch?v=prcdXzhS5EE
https://www.youtube.com/watch?v=y5CcncRHl38

6. Summarise your observations:

Conduct a comprehensive assessment by considering history (including upashaya anupashaya), a thorough physical examination, systemic examination, and relevant investigations. Additionally, perform a differential diagnosis (sapeksha and vyavachedaka nidana) based on the gathered data.

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ROGA NIDAN EVAM VIKRITI VIGYAN ACTIVITY BOOK

SERIAL NO: 6 **CLINICAL NO: C 6.5 & 6.7**

1. Activity Name

Oral & Abdominal examination

2. Activity Description:

Perform and record oral and abdominal examination of patient. Write your observations and interpretation on possible conditions the patient is suffering from.

3. Materials and Equipment:

Case format, Stethoscope, Sphygmomanometer, Thermometer, Pen torch, Measuring tape, Disposable tongue depressors, Cotton swabs, Disposable tissues or wipes, Rulers or Scales and Hand sanitizer.

4. Patient information:

Age:

Sex: M/ F/Others

Marital status:

Education:

Occupation:

Religion:

Socio-economic status:

Date of Consultation:

Out Patient Number:

Date of Admission:

In Patient Number:

Bed number:

Place of residence:

5. Oral and abdominal examination:

Prashna pareeksha – Short history (Including upashaya anupashaya) – Relevant to the patient:

Oral examination:

Write the observations for

Jihwa pareeksha - Tongue (normal/ colour/ fissure/ glossitis/ coated/ bald/ ulcerated/ geographic) (Tongue – atrophy of papillae, ulcers and white lesions, and enlargement of tongue):

Gum bleeding: Present/ Absent

With your observation and inference:

Per abdominal examination (Specify the area and side wherever applicable):

Darshanendriyataha pareeksha – Inspection:

Write your observation on [1]Udara akriti (Mandala udara/ Adhmaata udara/ Udara utseda); Shape of the abdomen (normal/ scaphoid/ distended/ fullness of the flanks);

[2]Nabhi pareeksha – Umbilicus: Normal/ Everted/ Scarring

[3]Distended veins - Sira santhata (Caput medusa/Collateral veins)
[4]Skin striae - Raji janma or raji santhata

[5]Discoloration of skin – Varna - (Cullen's sign, Turner's sign)

[6]Visible peristalsis: Examine in a step ladder pattern/ left to right/ right to left

[7]Antra vruddhi - Hernia orifices

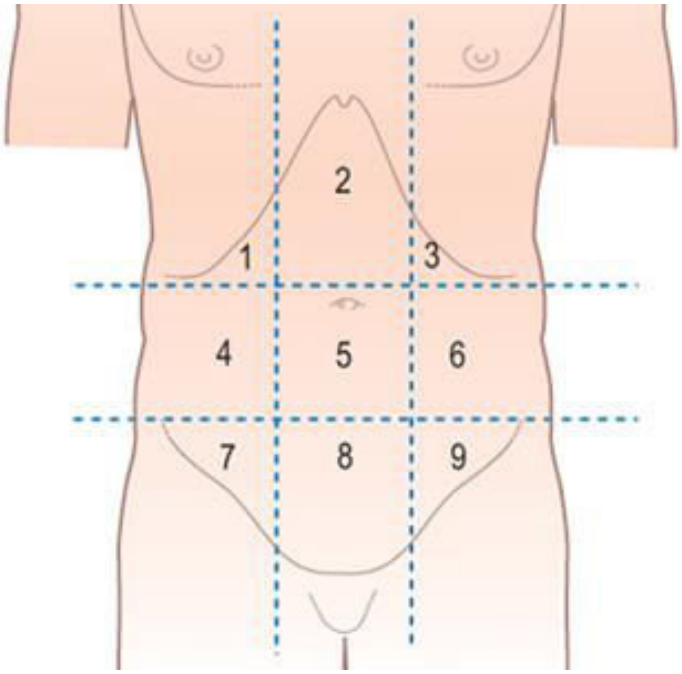
Feature to be inspected for	Observation	Inference
[1]Udara akriti		
[2]Nabhi pareeksha		
[3]Sira santhata	Present/ Absent	
[4]Raji janma	Present/ Absent	
[5]Varna	Normal/ Abnormal	
Movement of the different parts of the abdomen	Present/ Absent	
Visible pulsation	Present/ Absent	
Divarication of rectus abdominis	Present/ Absent	
Scars and sinuses	Present/ Absent	
Visible mass	Present/ Absent	
Sister Mary Joseph nodule	Present/ Absent	
[6]Visible peristalsis	Present/ Absent	
[7]Antra vruddhi	Visible/ Not visible	

Sparshanendriyataha pareeksha - Palpation (superficial palpation, deep palpation, bimanual palpation, ballottement, and dipping method) – Mention the observations in table and mark on the diagram given below:

Palpation	Observation	Inference
Sparsha asahata - Tenderness	Present/ Absent	

Ashaya vruddhi – Organomegaly. (If organomegaly present answer for below)	Present/ Absent	
Yakrut vruddhi - Liver	Size…….. Surface: Regular/ Irregular	
Basti vruddhi - Kidney	Right/ Left	
Pleeha vruddhi - Spleen	Not palpable/ Palpable	
Mootra ashaya vruddhi - Urinary bladder	Not palpable/ Palpable	

Mark and mention the observations regarding palpation on the diagram given below:



[Image source: Elsevier. Swash & Glynn: Hutchison's Clinical Methods 22e]

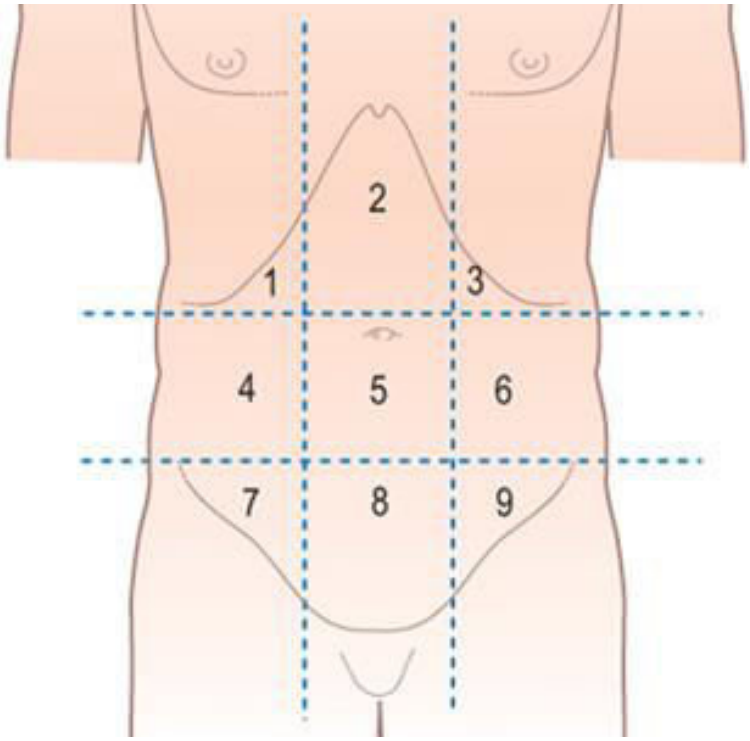
Shabdha prakshobha pareeksha – Percussion:

Mention the observations regarding percussion in table and mark on the diagram given below:

Per Abdominal - Percussion note	Observation Yes/ No (If Yes specify area)	Inference
Hyper resonant		
Resonant		
Dull		
Stony dull		

Special test for ascites - Percussion	Observation	Inference
Puddle sign	Present/ Absent	
Shifting dullness - Udaka poorna druti shabdha	Present/ Absent	
Horseshoe-shaped dullness - Udaka poorna druti shabdha	Present/ Absent	
Fluid thrill - Udaka poorna druti sparsha	Present/ Absent	

Mark and mention the observations regarding percussion on the diagram given below:



[Image source: Elsevier. Swash & Glynn: Hutchison's Clinical Methods 22e]

Shrotrendriyataha pareeksha – Auscultation:

Auscultation	Observation	Inference
Bowel sounds	If Yes, mention number per minute	
Succussion splash over abdomen	Present/ Absent	
Arterial bruits/ venous hums	Present/ Absent	

6. Summarise your observations:

Conduct a comprehensive assessment by considering history (including upashaya anupashaya), a thorough physical examination, systemic examination, and relevant investigations. Additionally, perform a differential diagnosis (sapeksha and vyavachedaka nidana) based on the gathered data.

Teacher's signature

ROGA NIDAN EVAM VIKRITI VIGYAN ACTIVITY BOOK

SERIAL NO: 6 **CLINICAL NO: C 6.6 & 6.8**

1. Activity Name

Nervous system examination

2. Activity Description:

Perform and record nervous system examination of patient. Write your observations and inference on possible conditions the patient is suffering from.

3. Materials and Equipment:

Case format, Pen torch, Reflex hammer, Tuning fork (More than or equal to 128 Hz) Measuring tape, Cotton swabs, Disposable tissues or wipes, Coffee and Tea powder sachet, Pins, Visual acuity and Ishihara colour charts and Hand sanitizer.

4. Patient information:

Age:

Sex: M/ F/Others

Marital status:

Education:

Occupation:

Religion:

Socio-economic status:

Date of Consultation:

Out Patient Number:

Date of Admission:

In Patient Number:

Bed number:

Place of residence:

5. Nervous system examination:

Prashna pareeksha – Short history (Including upashaya anupashaya) – Relevant to the patient:

1. Sangya jnana - Level of consciousness and orientation (Place person time)

Assess the level of consciousness: response to eye opening/ painful stimuli and verbal response. Normal – fully conscious and alert; Stuporous/ drowsy – response to verbal/ painful stimuli; Comatose – no response (Glasgow coma Scale - GCS) and write the inference

Glasgow Coma Scale Scoring	Inference
E - ; V - ; M -	

Assess the orientation (to place / person / time) and write the inference

Orientated to Place Person and Time	Inference
Yes/ No -	

2. Vak indriya - Speech and language

Shabdha pareeksha – Examining voice and speech of patient:

Speech defect	Contemporary understanding	Observation	Inference
Mooka, Vak sangha, Jihvataleshvalasastu	Aphasia	**Yes/ No**	
Minmina	Hyper nasal speech	**Yes/ No**	
Gadgada, Vak stambha, Kala vak	Dysarthria	**Yes/ No**	
Vakya graha	Dysprosody	**Yes/ No**	
Svaraghna	Hoarseness	**Yes/ No**	
Deena svara	Dysphonia	**Yes/ No**	
Deena vak	Scanning speech	**Yes/ No**	
Jihma vak	Apraxia	**Yes/ No**	
Samutkshipta vak	Cluttering speech	**Yes/ No**	

3. Uhya - Perceptions

Assess the Uhya - Perceptions (Sensory awareness of object and its relation) including hallucination and delusions and write the inference

Mention the perceptions	Observation	Inference
Hallucination	Present/ Absent	
Delusions	Present/ Absent	

4. Smriti – Memory

Assess the Remote memory/Recent memory and write your inference

Mention about memory	Observation	Inference
Recent memory	Present/ Absent	
Remote memory	Present/ Absent	

Cranial nerve examination (Sensory & Motor):

Mention side (right and left) wherever applicable

Cranial nerve	Components to be examined	Write your observation on mentioned components and conclude with your inference
Olfactory nerve	Gandha jnana – **Sense of olfaction…….**	
Optic nerve	Netradeenam cha vaikrutim – **Visual acuity……..** **Visual field……** **Colour vision……..** **Fundi……**	
Oculomotor, Trochlear, Abducens	Sthabdha Netra/ Netradeenam cha vaikrutim – **Pupil size…….** **Symmetry…….** **Light reflex…….** **Consensual reflex……** **Accommodation reflex……..** **Ptosis……** **Squint……** **Nystagmus…..** **Conjugate eye ball movement…….** **Diplopia (concomitant/ paralytic)……**	
Trigeminal nerve	Vakrikaroti hanu/ Shankha/ Shravana/ Ganda ruk – **Sensory part:** **Corneal reflex……**	

	Others (Ophthalmic, Maxillary & Mandibular branch observations)…… **Motor part:** **Jaw clenching…….** **Lateral jaw movement……** **Glabellar reflex…….**	
Facial nerve	Vakri karoti nasa bhru lalata/ Mukham jihmam/ Vrujati asye bhojana/ Kshavathu nigraha – **Motor part for Upper face:** **Raising eye brow.....** **Frowning the forehead.....** **Bell's phenomenon.....** **Motor part for Lower face:** **Nasolabial fold.....** **Clenching the teeth.....** **Whistling.....** **Blowing the mouth.....** **Taste sensation (Anterior 2/3rd of tongue): ……**	
Vestibulo cochlear nerve	Badyate shravana – **Cochlear component:** **Rinne's test…….** **Weber's test……** **Hearing tests - impression……..** **Conductive/ sensori neural/ mixed**	

	Vestibular component: Nystagmus/ calorie test:…….	
Glossopharyngeal nerve and vagus nerve	Bhidyate swara/ Mukham jihmam – **Position of uvula…….** **Taste perception (Posterior 1/3rd of tongue)……..** **Gag reflex……..**	
Spinal accessory nerve	Upashoshya bahum – **Sternocleidomastoid muscle…….** **Trapezius muscle……**	
Hypoglossal nerve	Mukham jihmam – **Wasting: Absent/ present……..** **Fasciculations: Absent/ present…….** **Deviation: Right side/ left side** **Movements of tongue: Normal/ abnormal…….** **Power of tongue……**	
Summary		
Affected nerve	**Sensory**	**Motor**

Karmendriya pareeksha/ Chesta - Motor system examination (Specify site examined with side of body wherever applicable):

Mamsa pareeksha/ Mamsa bala/ Supushta mamsa/ Bala heena mamsa – Muscle bulk, Muscle Power and Muscle tone examination.

Evaluate the muscle mass at different locations in centimetres, specifying the type of muscle bulk and providing your analysis. Assess the area 10 cm above the elbow for the arm and below the elbow for the forearm, referencing the olecranon process of upper limb. Measure 18 cm above the patella for the thigh and 10 cm below the tibial tuberosity for the calf. Report your findings accordingly.

Limb	**Muscle bulk (Mention the side and site of measurement along with comparing side)**	**Normal/ Atrophy (Anga shosha)/ Hypertrophy/ Pseudohypertrophy**	**Inference**
Upper limbs (Arm/ Fore arm)			
Lower limbs (Thigh/ Calf)			

Assess the muscle power of various sites with grading and your inference

***Muscle power** grading chart:

0 – no muscle contraction visible
1 – muscle contraction visible, but no movement of joint
2 – joint movement with gravity elimination
3 – movement sufficient to overcome gravity
4 – movement overcomes gravity with added resistance
5 – normal power with full resistance

Limb	Location for examining Muscle power with side	Mention Muscle power grading*	Inference
Upper limbs			
Lower limbs			

Assess the **muscle tone** of various sites with observation and your inference

Limb	Location for examining Muscle tone	Mention Muscle tone type (Normotonic/ Hypotonic or flaccid (Shaithilya)/ Hypertonic (Sankocha) – Clasp knife, Lead pipe, Cog wheel)	Inference
Upper limbs			
Lower limbs			

Reflexes: hyperreflexia/ hyporeflexia – *Shareera dhatu vyuhakara, sandhanakara shareerasya*:

Assess the reflexes of various sites with observation and your inference. Mention grades of reflex –

DTR Grading	
0	Absent (areflexia)
1	Diminished (hyporeflexia)
2	Average (normal)
3	Exaggerated (brisk)
4	Clonus, very brisk (hyperreflexia)

[Image Source: Quizlet Flash Cards]

Reflex	Observation (Hyper-reflexia/ Hypo-reflexia/ Areflexia)	Inference
Deep tendon reflexes		
Biceps jerk		
Triceps jerk		
Supinator jerk		
Jaw jerk		
Knee jerk		
Ankle jerk		
Superficial reflexes		
Cremasteric reflex		
Babinski sign		
Abdominal reflex		

Kampa/ Vepathu – Involuntary movements **-** Absent/ Present (If Present mention details below):

Rhythmic	Absent/ Present – Resting tremor	
Non rhythmic	Absent/ Present – Intention tremor/ Chorea/ Athetosis/ Ballismus/ Hemiballismus/ Myoclonus/ Asterixis	

Anga gati pareeksha/ Skalita gati pareeksha - Co-ordination assessment tests:

Assess the coordination of the patient using following methods, write your observation and inference below

	Name of test/ condition	**Coordination Present/ Absent**	**Inference**
Rapid alternating movements	Rapid alternating movements of arms		
	Finger tapping (Index finger and Thumb)		
	Rapid alternating movements of foot (Touching ball of foot with arms)		
Point to point movements	Finger nose test		
	Heel to shin test		
Gait	Tandem walking		
	Walking on toes and heels		
	Hop in place		
	Shallow knee bending		

	Rising from sitting position (without arm support)		
Stance	Romberg's test		
	Pronator drift test		
Dysdiadochokinesia		Present/ Absent	

Gati pareeksha – Gait:

Assess the gait of the patient, write your observation and inference below.

Gait – Intact/ Affected; If affected mention the type with inference (Scissor gait, Stamping gait, High stepping gait, Festinating gait, Ataxic gait, Hemiplegic gait)

Mention type of gait observed	Inference

Sparsha jnana pareeksha (Supti/ Sparsha ajnana, etc.) - Sensory system examination:

Sensation of touch:

Touch sensation	Dermatome	Observation	Inference
Crude touch			
Fine touch			
Two-point discrimination			
Point localization			

Sensation of Pain and pressure:

Pain and pressure	Dermatome	Observation	Inference
Pain			
Pressure			

Temperature sensation:

Temperature	Dermatome	Observation	Inference
Temperature			

Assess the joint position for various joints and write your observation and inference

Joint position	Joint	Observation	Inference

Assess the Vibration sensation on designated sites of body and write your observation and inference

Site of body	Observation	Inference

Assess the *Stereognosis and **Graphesthesia on designated sites of body and write your observation and inference

Site of body	Observation*	Inference

Site of body	Observation**	Inference

Write your inference on below mentioned points:

Sl. No	Observation	Dosha and dushya involvement	Inference to be made based on guna of vata
1			
2			
3			
4			

Conduct a comprehensive assessment by considering history (including upashaya anupashaya), a thorough physical examination, systemic examination, and relevant investigations. Additionally, perform a differential diagnosis (sapeksha and vyavachedaka nidana) based on the gathered data.

Teacher's signature

ROGA NIDAN EVAM VIKRITI VIGYAN ACTIVITY BOOK

SERIAL NO: 6 **CLINICAL NO: C 6.9 & 6.11**

1. Activity Name

Musculoskeletal system examination

2. Activity Description:

Perform and record musculoskeletal system examination of patient. Write your observations and inference on possible conditions the patient is suffering from.

3. Materials and Equipment:

Case format, Pen torch, Reflex hammer, Tuning fork, Measuring tape, Disposable tissues or wipes, Goniometer and Hand sanitizer.

4. Patient information:

Age:

Sex: M/ F/Others

Marital status:

Education:

Occupation:

Religion:

Socio-economic status:

Date of Consultation:

Out Patient Number:

Date of Admission:

In Patient Number:

Bed number:

Place of residence:

5. Musculoskeletal system examination:

Prashna pareeksha – Short history (Including upashaya anupashaya) – Relevant to the patient:

Darshnendriyataha pareeksha – Inspection (Mention location and side of examination wherever applicable):

Gati pareeksha – Gait:

Gait – Affected/ Not Affected; If affected mention the type

Mention type of gait observed	Inference
Antalgic gait	
Trendelenburg gait	
Any other	

Sl No	Joints	Inspection			
		Sandhi Shotha (Swelling)	Sandhi vaivarnya/ Raga (Redness)	Sandhi karma (Prasaarana akuncana)	Sandhi vaikalyata (Deformity)
1	Temporomandibular				
2	Shoulder				
3	Elbow				

4	Wrist and hand				
5	Hip				
6	Knee joint				
7	Ankle and foot				

Sparshanendriyataha pareeksha – Palpation (Mention location and side of examination wherever applicable):

Sl No	Joints	Palpation		
		Sandhi Shotha (Swelling)	**Sandhi ushnata (Local rise of Temperature)**	**Sandhi sparsha asahanata (Tenderness)**
1	Temporomandibular			
2	Shoulder			
3	Elbow			
4	Wrist and hand			
5	Hip			
6	Knee			
7	Ankle and foot			

Spine:

Feature to be observed	*Mention the abnormality observed	Inference
Deformity *(Kyphosis/ Scoliosis/ Lordosis/ Stepping in spine; Loss of normal curvatures at different levels)		
Gibbus		

Cervical spine:

Feature to be observed/ Tests	*Mention the abnormality observed	Inference
Tenderness		
Foramina compression test		
Lhermitte's sign (Lhermitte's phenomenon)		
Range of movements		

Lumbar spine:

Feature to be observed/ Tests	*Mention the abnormality observed	Inference
Tenderness		
Range of movements		
SLR test (Sakthnaha kshepam nigraha): Positive/ Negative		
If SLR Test is Positive Mention Range Bragard's test Lasegue's sign		
Femoral nerve root compression test: (Sakthnaha kshepam nigraha): Positive/ Negative		

Knee joint:

Feature to be observed/ Tests	*Mention the abnormality observed	Inference
Grind test		
Patellar tap test		

Baker’s cyst		
Crepitus		

Write your inference on below mentioned points:

Sl. No	Observation	Dosha and dushya involvement	Inference to be made based on guna of vata
1			
2			
3			
4			

Conduct a comprehensive assessment by considering history (including upashaya anupashaya), a thorough physical examination, systemic examination, and relevant investigations. Additionally, perform a differential diagnosis (sapeksha and vyavachedaka nidana) based on the gathered data.

Teacher’s signature

ROGA NIDAN EVAM VIKRITI VIGYAN ACTIVITY BOOK

SERIAL NO: 6 **CLINICAL NO: C 6.10 & 6.12**

1. Activity Name

Integumentary system examination

2. Activity Description:

Perform and record integumentary system examination of patient. Write your observations and inference on possible conditions the patient is suffering from.

3. Materials and Equipment:

Case format, Pen torch, Magnifying glass, Glass slide, Scale or skin callipers, Markers, Disposable tissues or wipes and Hand sanitizer.

4. Patient information:

Age:

Sex: M/ F/Others

Marital status:

Education:

Occupation:

Religion:

Socio-economic status:

Date of Consultation:

Out Patient Number:

Date of Admission:

In Patient Number:

Bed number:

Place of residence:

5. Integumentary system examination:

Prashna pareeksha – Short history (Including upashaya anupashaya) – Relevant to the patient:

Tvak pareeksha - Assessment of skin:

Inspection:

Varna/ Colour: Shyava aruna, Raga, Shweta, Krishna, Aruna, Raktaparyanta, Shyava, Taamra, Peetaparyanta, Neela, Peeta, Varnabheda, etc.

Size and shape: Khara paryanta, Utsanna madhya, Tanu paryanta, Hrsva, Dheergha, Mandala, Vishama, Vistrta, Yagjnopaveeta sankasha, etc.
Dome shaped – Trichoepithelioma, Flat topped - Verruca plana, Umbilicated - Molluscum contagiosum, Acuminate - Condylomata acuminata, Verrucous - Verruca vulgaris, Pedunculated – Skin tags.

Configuration: Annular - T. corporis, Granuloma annulare, Round/ discoid - Nummular eczema, discoid lupus. Polycyclic - Urticaria, Sub Cutaneous Lupus Erythematosus, Arcuate - Urticaria. Linear - Scabies burrow, Lichen nitidus. Kobners phenomenon. Reticular - Livedo reticularis, Serpiginous - cutaneous larva migrans, Targetoid lesions-

with 3 distinct zones. Erythema multiforme. Whorled - Incontinentia pigmenti.

Arrangement of lesion: Grouped/ herpetiform - HSV-1, Scattered

Distribution of lesions: Dermatomal/ zosteriform. Blaschkoid - Following lines of skin cell migration during embryogenesis. Longitudinal on limbs. Circumferential on trunk. Lymphangitic - strep. Or staph cellulitis. Sun exposed - Photodermatitis, Polymorphous Light Eruption, Subcutaneous Lupus Erythematosus, Sun protected - Parapsoriasis, Mycosis fungoides. Acral - Chilblains, Palmoplantar pustulosis. Truncal, Extensor – Psoriasis, Flexor-atopic dermatitis, Intertriginous – Candidiasis, Localized – Cellulitis, Generalized-exanthema, Drug eruptions. B/L (Bilateral) symmetrical – Vitiligo. Universal - Alopecia universalis.

***Type of skin lesion (Primary)**	**[1]Colour and pigmentation of lesion**	**Size**	**[1]Configuration and symmetry of lesion**	**Arrangement of lesion**	**Distribution over the body surface**
Vaivarnya – Macule/ Patch					
Sookshma pidaka - Papule					
Udvrtta pidaka - Plaque					
Granthi - Nodule					
Varathi dashta samsthana shotha - Wheal					

Sphota - Vesicle					
Vishphota – Bullae					
Putimamsa pidaka - Pustule					

*Type of skin lesion (Secondary)	Colour and pigmentation	Size	Shape and symmetry	Distribution over the body surface
Grushta Vrana - Erosion				
Vrana - Ulcer				
Daari - Fissure				
Sthira cipitika - Crust				
Shakala - Scale				
Charmakhya – Lichenification and Hyperkeratinisation				
Kshaya - Atrophy				
Rajyo ati kandu - Excoriation				
Vruna vastu – Scar				
Neelika, Mashaka – Nevus				
Pidaka – Comedone				
Bahya Krimi pidaka - Burrow of scabies				
Sirajala – Telangiectasia				
Any other				

Palpation/ sensation/ deformities/ odour:

*Enquire and perform for following parameters:

Palpation:

Specify – Rooksha, Khara, Parushya, Daha, Kleda, Snigdha, Shaitya, Ghana, etc.

Sensory symptoms: Specify – Toda (Sparsha akshamatva), Prakwatita daha, Tvak svapa, Harsha, etc.

Deformity: Tvak sankocha, Tvak ayaama, Tvak shosha, Kaunya, Angulipatana, Anga patina, Karna nasa bhanga, etc.

Odour/ Srava/ Krimi/ etc:

Visra gandha, etc.
Puya srava/ Lasika srava/ Puya rakta/ Lasika srava/ Bahu bahala picchila rakta srava etc.
Krimi janma, etc.

Type of skin lesion	***Palpation (Texture/ temperature)**	***Sensory symptoms (Tvak swapa/ daha)**	***Deformity**	***Odour/ Srava/ Krimi**

Special tests:

Special tests	**Observation**	**Inference**
Candle grease sign		
Auspitz's sign		
Koebner's phenomenon		
Blanch test		
Nikolsky's sign		

Any other observations		

Any other special tests and observations can be mentioned here:

Nakha pareeksha - Assessment of nail and nail bed:

*Abnormalities like clubbing of fingers, paronychia, onycholysis, Terry's nails, white spots (leukonychia), transverse white lines (Mees' lines), Pitting of nails - Psoriasis, and Beau's lines

Nail:

***Features to be examined**	**Observation**	**Inference**
Colour		
Shape		
Any lesion		

Nail bed:

Nail bed tenderness – Present/ Absent
Swelling – Present/ Absent
Redness – Present/ Absent

Kesha pareeksha - Assessment of hair:

*Distribution Khalitya (Alopecia Areata, Androgenetic Alopecia, Central Centrifugal Cicatricial Alopecia, Chemotherapy Induced

Alopecia, Frontal Fibrosing Alopecia, Lichen Planopilaris, Telogen Effluvium, Traction Alopecia, Trichotillomania) and Palitya (colour):

*Features to be examined	Observation	Inference
Quantity		
Distribution		
Texture		
Colour		

Tick Appropriate:

Onset of Khalitya: Kalaja/ Akalaja
Onset of Palitya: Kalaja/ Akalaja

Write your inference on below mentioned points:

Sl. No	Parameters to be assessed	Item observed in patient	Rationality
1	Dosha – Anubandhya and Anubandha dosha		
2	Dushya		

Conduct a comprehensive assessment by considering history (including upashaya anupashaya), a thorough physical examination, systemic examination, and relevant investigations. Additionally, perform a differential diagnosis (sapeksha and vyavachedaka nidana) based on the gathered data.

Teacher's signature

ROGA NIDAN EVAM VIKRITI VIGYAN ACTIVITY BOOK

SERIAL NO: 7 CLINICAL NO: C 7.1

Anemia evaluation – ABC (45 years) has been experiencing fatigue, weakness, and shortness of breath for the past few months. He has noticed a decrease in his exercise tolerance and feels tired even after minimal physical exertion. He denies any significant weight loss, changes in appetite, or other associated symptoms. His medical history is unremarkable, and he takes no regular medications. There is no family history of anemia or other significant medical conditions.

Initial Physical Examination:

- General appearance: Pale conjunctiva and skin
- Vital signs: Blood pressure 120/80 mmHg, pulse rate 90 bpm, respiratory rate 16 breaths per minute, temperature 98.6°F (37°C)
- Cardiovascular examination: Regular heart sounds, no murmurs
- Respiratory examination: Normal breath sounds
- Abdominal examination: No hepatosplenomegaly or masses
- Extremities: No peripheral edema or clubbing

List of Tests for Anaemia Evaluation:

Preliminary tests:

1. Complete Blood Count (CBC): Red blood cells (RBCs), Hemoglobin, Hematocrit, Mean corpuscular volume (MCV), Mean corpuscular hemoglobin (MCH), Mean corpuscular hemoglobin concentration (MCHC), and Red cell distribution width (RDW)
2. Peripheral Blood Smear
3. Reticulocyte Count

Further investigation:

4. Iron Studies: Serum iron, Total iron-binding capacity (TIBC), and Ferritin levels
5. Vitamin B12 and Folate Levels
6. Renal Function Tests
7. Bone Marrow Aspiration and Biopsy

Mention the patient preparation, sample collection, type of investigation, indication, and interpretation of Sl. No 1(Excluding platelets) and 2

Materials required: Format to fill, Laboratory methods/ Clinical pathology textbooks if required.

1. Complete Blood Count (CBC): Red blood cells (RBCs), hemoglobin, hematocrit, mean corpuscular volume (MCV), mean corpuscular hemoglobin (MCH), meancorpuscular hemoglobin concentration (MCHC), and Red cell distribution width (RDW)

Patient preparation:

Sample collection:

Type of investigation:

Indication:

Interpretation:

(Add additional page if required)

2. Peripheral Blood Smear:

Patient preparation:

Sample collection:

Type of investigation:

Indication:

Interpretation:

(Add additional page if required)

Teacher's signature

ROGA NIDAN EVAM VIKRITI VIGYAN ACTIVITY BOOK

SERIAL NO: 7 CLINICAL NO: C 7.2

UTI evaluation – ABC (30 years) complains of increased frequency of urination, accompanied by a burning sensation during urination and lower abdominal pain for the past two days. She denies any fever, back pain, or blood in the urine. ABC has a history of recurrent UTIs and is sexually active. She has no known allergies and takes no regular medications.

Initial Physical Examination:

- Vital signs: Blood pressure 120/80 mmHg, pulse rate 80 bpm, respiratory rate 16 breaths per minute, temperature 98.6°F (37°C)
- Abdominal examination: Mild tenderness in the lower abdomen
- Genitourinary examination: No abnormal findings, no cervical discharge

List of Tests for UTI Evaluation:

Preliminary tests:

1. Urinalysis:

   Urine physical examination (Appearance, Colour, Odor, Urine specific gravity)

   Urine chemical examination (Urine-pH, Sugar, Albumin, Bile pigment, Bile salt, Occult blood, Ketones, Urobilinogen)

   Urine microscopic examination (Epithelial cells, WBCs, RBCs, Leukocytes, Casts, Crystals and) bacteria (suggesting a bacterial infection)

2. Complete Blood Count (CBC)
3. C-reactive protein (CRP)

Further investigation:

4. Urine Culture and Sensitivity
5. Imaging Studies: Ultrasound or CT scan.
6. VDRL
7. Urethral Swab or Vaginal Swab.

Mention the patient preparation, sample collection, type of investigation, indication, and interpretation of Sl. No 1 and 6.

Materials required: Format to fill, Laboratory methods/ Clinical pathology textbooks if required.

1. Urinalysis: Urine physical examination (Appearance, Color, Odor, Specific gravity), chemical examination (Urine-pH, Sugar, Albumin, Bile pigment, Bile salt, blood, Ketone, Urobilinogen), Microscopic Examination (Epithelial cells, WBCs, RBCs, Leukocytes, Casts, Crystals) and bacteria (suggesting a bacterial infection):

Patient preparation:

Sample collection:

Type of investigation:

Indication:

Interpretation:

2. VDRL:

Patient preparation:

Sample collection:

Type of investigation:

Indication:

Interpretation:

(Add additional page if required)

Teacher's signature

ROGA NIDAN EVAM VIKRITI VIGYAN ACTIVITY BOOK

SERIAL NO: 7 CLINICAL NO: C 7.3

Hepatic evaluation – ABC (50 years) presents with complaints of persistent abdominal pain, yellowing of the skin and eyes (jaundice), and significant fatigue. He has a long history of heavy alcohol consumption, consuming approximately 8 to 10 alcoholic drinks per day for the past 20 years. He admits to having trouble controlling his alcohol intake and has previously experienced episodes of alcohol-related liver inflammation. He has no known allergies and takes no regular medications.

Initial Physical Examination:

- General appearance: Jaundiced, fatigue
- Vital signs: Blood pressure 130/80 mmHg, pulse rate 90 bpm, respiratory rate 18 breaths per minute, temperature 99.1°F (37.3°C)
- Abdominal examination: Tenderness in the right upper quadrant, hepatomegaly (enlarged liver), and possibly splenomegaly (enlarged spleen)
- Skin examination: Spider angiomas (tiny blood vessels visible on the skin), palmar erythema (redness of the palms), and jaundice

List of Tests for Alcoholic Liver Disease (ALD) Evaluation:

Preliminary tests:

1. Liver Function Tests: AST, ALT, GGT, Bilirubin levels, Protein levels, Prothrombin time, Clotting time.
2. Imaging Studies: Abdominal Ultrasound

Further investigation:

3. Complete Blood Count (CBC)
4. Imaging Studies: FibroScan or Transient Elastography
5. Viral Hepatitis Serology
6. Serum Ferritin and Iron Studies
7. Alpha-fetoprotein (AFP) Level
8. Coagulation Profile
9. Gastroscopy

Mention the patient preparation, sample collection, type of investigation, indication, and interpretation of Sl. No 1 and 8.

Materials required: Format to fill, Laboratory methods/ Clinical pathology textbooks if required.

1. Liver Function Tests: AST, ALT, and GGT, bilirubin levels, albumin levels, and prothrombin time, clotting time

Patient preparation:

Sample collection:

Type of investigation:

Indication:

Interpretation:

2. Coagulation profile

Patient preparation:

Sample collection:

Type of investigation:

Indication:

Interpretation:

(Add additional page if required)

Teacher's signature

ROGA NIDAN EVAM VIKRITI VIGYAN ACTIVITY BOOK

SERIAL NO: 7 CLINICAL NO: C 7.4

Renal evaluation – ABC (60 years) presents with complaints of persistent fatigue, decreased urine output, and swelling in her legs for the past few months. She has a medical history of hypertension and diabetes, both of which have been poorly controlled. She also reports a family history of kidney disease. She takes medications for her underlying conditions but admits to being non-compliant with her prescribed medications. She has no known allergies.

Initial Physical Examination:

- General appearance: Fatigue and lethargy
- Vital signs: Blood pressure 160/90 mmHg, pulse rate 80 bpm, respiratory rate 16 breaths per minute, temperature 98.6°F (37°C)
- Abdominal examination: No specific findings
- Extremities examination: Lower extremity edema

List of Tests for Chronic Kidney Disease (CKD) Evaluation:

Preliminary tests:

1. Renal Function Tests: Serum Creatinine, Blood Urea Nitrogen (BUN), Serum uric acid
2. Estimated Glomerular Filtration Rate (eGFR)
3. Urinalysis
4. Urine Albumin-to-Creatinine Ratio (ACR)
5. Imaging Studies: Renal Ultrasound

Further investigation:

6. Complete Blood Count (CBC)
7. Electrolyte Levels: Serum Potassium, Serum Sodium and Serum Chloride
8. Serum Calcium and Phosphate
9. Lipid Profile
10. Blood Glucose Levels
11. Kidney Biopsy

Mention the patient preparation, sample collection, type of investigation, indication, and interpretation of Sl. No 1, 4, 7 and 8

Materials required: Format to fill, Laboratory methods/ Clinical pathology textbooks if required.

1. Renal Function Tests: Serum Creatinine, Blood Urea Nitrogen (BUN), Serum uric acid

Patient preparation:

Sample collection:

Type of investigation:

Indication:

Interpretation:

2. Urine Albumin-to-Creatinine Ratio (ACR)

Patient preparation:

Sample collection:

Type of investigation:

Indication:

Interpretation:

3. Electrolyte Levels: Serum Potassium, Serum Sodium and Serum Chloride

Patient preparation:

Sample collection:

Type of investigation:

Indication:

Interpretation:

4. Serum Calcium and Phosphate

Patient preparation:

Sample collection:

Type of investigation:

Indication:

Interpretation:

Teacher's signature

ROGA NIDAN EVAM VIKRITI VIGYAN ACTIVITY BOOK

SERIAL NO: 7 CLINICAL NO: C 7.5

Thyroid evaluation – ABC (35 years) presents with complaints of persistent fatigue, unexplained weight gain, feeling cold all the time, and constipation. She has noticed a decrease in her energy levels and a gradual increase in her weight over the past few months. She has a family history of thyroid disorders. She takes no regular medications and has no known allergies.

Initial Physical Examination:

- General appearance: Fatigue and lethargy
- Vital signs: Blood pressure 120/80 mmHg, pulse rate 70 bpm, respiratory rate 16 breaths per minute, temperature 98.6°F (37°C)
- Skin examination: Dry skin, hair loss, and brittle nails
- Neurological examination: Slow reflexes, slow speech, and slowed mental processes

List of Tests for Hypothyroidism Evaluation:

Preliminary tests:

1. Thyroid Function Tests: Thyroid-Stimulating Hormone (TSH) Level, T3, T4,F T3, F T4
2. Antithyroid Antibodies (Anti-thyroid peroxidase)

Further investigation:

3. Lipid Profile
4. Complete Blood Count (CBC)
5. Additional tests: Basal Body Temperature, Serum Prolactin Level, Electrocardiogram (ECG)

Mention the patient preparation, sample collection, type of investigation, indication, and interpretation of Sl. No 1

Materials required: Format to fill, Laboratory methods/ Clinical pathology textbooks ifrequired.

1. **Thyroid Function Tests:** Thyroid-Stimulating Hormone (TSH) Level, T3, T4, F T3, FT4

   Patient preparation:

   Sample collection:

   Type of investigation:

   Indication:

   Interpretation:

Teacher's signature

ROGA NIDAN EVAM VIKRITI VIGYAN ACTIVITY BOOK

SERIAL NO: 7 CLINICAL NO: C 7.6

Diabetes Mellitus evaluation – XYZ (45 years) presents with complaints of increased thirst, frequent urination, and unexplained weight loss over the past few months. He also reports feeling tired and experiencing blurred vision. He has a family history of diabetes. He takes no regular medications and has no known allergies.

Initial Physical Examination:

- General appearance: Alert and oriented
- Vital signs: Blood pressure 130/80 mmHg, pulse rate 80 bpm, respiratory rate 16 breaths per minute, temperature 98.6°F (37°C)
- Skin examination: No specific findings
- Neurological examination: No abnormalities

List of Tests for Diabetes Mellitus Evaluation:

Preliminary tests:

1. Fasting Plasma Glucose (FPG) Test
2. Postprandial Plasma Glucose (PPPG)
3. Glycated Hemoglobin (HbA1c) Test

Further investigation:

4. Oral Glucose Tolerance Test (OGTT)
5. Urine Analysis
6. Lipid Profile
7. Kidney Function Tests: Serum Creatinine, Blood Urea Nitrogen (BUN), Urine Albumin-to-Creatinine Ratio (ACR)
8. C- peptide Level
9. Liver Function Tests
10. Thyroid Function Tests
11. Additional Tests: Autoantibodies (Islet cell antibodies, Insulin autoantibodies)

Mention the patient preparation, sample collection, type of investigation, indication, and interpretation of Sl. No 1 to 4 and Sl. No 8

Materials required: Format to fill, Laboratory methods/ Clinical pathology textbooks if required.

1. **Fasting Plasma Glucose (FPG) Test**

   Patient preparation:

   Sample collection:

   Type of investigation:

   Indication:

   Interpretation:

2. **Postprandial Plasma Glucose (PPPG)**

   Patient preparation:

Sample collection:

Type of investigation:

Indication:

Interpretation:

3. Glycated Hemoglobin (HbA1c) Test

Patient preparation:

Sample collection:

Type of investigation:

Indication:

Interpretation:

4. Oral Glucose Tolerance Test (OGTT)

Patient preparation:

Sample collection:

Type of investigation:

Indication:

Interpretation:

5. C – Peptide level

Patient preparation:

Sample collection:

Type of investigation:

Indication:

Interpretation:

(Add additional page if required)

Teacher's signature

ROGA NIDAN EVAM VIKRITI VIGYAN ACTIVITY BOOK

SERIAL NO: 7 CLINICAL NO: C 7.7

Stroke evaluation – ABC (60 years) presents with a sudden onset of weakness and numbness on the right side of his body. He has difficulty speaking and experiences confusion. There is no history of trauma or seizure activity. He has a past medical history of hypertension and smoking. He takes antihypertensive medication but is non-compliant with his treatment. He has no known allergies.

Initial Physical Examination:

- General appearance: Alert but appears anxious and distressed
- Vital signs: Blood pressure 160/90 mmHg, pulse rate 80 bpm, respiratory rate 18 breaths per minute, temperature 98.6°F (37°C)
- Neurological examination: Right-sided hemiparesis (weakness), right-sided sensory loss, dysarthria (difficulty speaking), and facial droop on the right side

List of Tests for Atherosclerotic Stroke Evaluation:

Preliminary tests:

1. Non-Contrast Computed Tomography (CT) Scan of the Brain
2. Magnetic Resonance Imaging (MRI) of the Brain
3. Lipid Profile: Total cholesterol, LDL cholesterol, HDL cholesterol, and Triglycerides

Further investigations:

4. Diabetic profile
5. Renal Function Tests
6. Electrocardiogram (ECG)
7. Carotid Doppler Ultrasound
8. Coagulation Profile
9. Complete Blood Count (CBC)
10. Additional Tests: Carotid Angiography, Holter Monitor
11. Transthoracic Echocardiogram (TTE) or Transesophageal Echocardiogram (TEE)

Mention the patient preparation, sample collection, type of investigation, indication, and interpretation of Sl. No 3

Materials required: Format to fill, Laboratory methods/ Clinical pathology textbooks if required.

1. **Total cholesterol, LDL cholesterol, HDL cholesterol, and triglycerides**

Patient preparation:

Sample collection:

Type of investigation:

Indication:

Interpretation:

(Add additional page if required)

Teacher's signature

ROGA NIDAN EVAM VIKRITI VIGYAN ACTIVITY BOOK

SERIAL NO: 7 CLINICAL NO: C 7.8

Arthritis evaluation – ABC (55 years) presents with complaints of joint pain, swelling, and stiffness in her hands, wrists, and knees. She reports that the symptoms have been persistent for the past few months and have been affecting her daily activities. She does not recall any recent injuries or trauma to the joints. She has no significant past medical history and no known allergies.

Initial Physical Examination:

- General appearance: Alert and in mild discomfort
- Vital signs: Blood pressure 120/80 mmHg, pulse rate 72 bpm, respiratory rate 16 breaths per minute, temperature 98.6°F (37°C)
- Musculoskeletal examination: Swelling and tenderness in the small joints of the hands and wrists, as well as the knees. Limited range of motion and crepitus may be noted.

List of Tests for Arthritis Evaluation:

Preliminary tests:

1. Rheumatoid Factor (RF), Antistreptolysin O (ASO) and Anti-Cyclic Citrullinated Peptide (anti-CCP) Antibody
2. Uric Acid Level
3. Erythrocyte Sedimentation Rate (ESR), C-Reactive Protein (CRP) Level
4. X-rays

Subsequent tests:

5. Antinuclear Antibodies (ANA) Profile
6. Complete Blood Count (CBC): White blood cell count and platelet
7. Joint Fluid Analysis
8. Ultrasound or Magnetic Resonance Imaging (MRI)

Mention the patient preparation, sample collection, type of investigation, indication, and interpretation of Sl. No 1 (RF & ASO), 3 (CRP)

Materials required: Format to fill, Laboratory methods/ Clinical pathology textbooks if required.

1. **RF/ ASO/ CRP**

   Patient preparation:

   Sample collection:

   Type of investigation:

   Indication:

   Interpretation:

(Add additional page if required)

Teacher's signature

ROGA NIDAN EVAM VIKRITI VIGYAN ACTIVITY BOOK

SERIAL NO: 7 CLINICAL NO: C 7.9

Fever evaluation – ABC (32 years) presents with complaints of persistent fever, abdominal pain, and gastrointestinal symptoms for the past week. She reports experiencing high-grade fever, reaching up to 104°F (40°C), along with severe headaches and body aches. She also mentions having abdominal pain, particularly in the right lower quadrant, and experiencing diarrhea with loose, watery stools. She denies any recent travel but mentions consuming food from street vendors. She has no significant past medical history and no known allergies.

Initial Physical Examination:

- General appearance: Fatigued, mildly dehydrated
- Vital signs: Blood pressure 120/80 mmHg, pulse rate 100 bpm, respiratory rate 18 breaths per minute, temperature 102.2°F (39°C)
- Abdominal examination: Tenderness in the right lower quadrant, possible hepatomegaly (enlarged liver)

List of Tests for Fever Evaluation:

Preliminary tests:

1. Complete Blood Count (CBC): Platelet, Total Leukocyte Count, Differential Leukocyte Count and Erythrocyte Sedimentation Rate
2. Bleeding time
3. Widal Test
4. Malarial parasite (Peripheral smear/ card test)
5. Dengue NS 1 – IgG, IgM (Card test)
6. Leptospirosis test
7. Urinalysis
8. Chest X-ray

Further investigation:

9. Blood Culture
10. Abdominal Ultrasound
11. Stool Culture
12. HIV Testing
13. Liver Function Tests

Mention the patient preparation, sample collection, type of investigation, indication, and interpretation of Sl. No 1, 2, 3, 4 and 5

Materials required: Format to fill, Laboratory methods/ Clinical pathology textbooks if required.

1. Complete Blood Count (CBC) – Platelet, Total Leukocyte Count, Differential Leukocyte Count, and Erythrocyte Sedimentation Rate

Patient preparation:

Sample collection:

Type of investigation:

Indication:

Interpretation:

2. Bleeding time

Patient preparation:

Sample collection:

Type of investigation:

Indication:

Interpretation:

3. Widal test

Patient preparation:

Sample collection:

Type of investigation:

Indication:

Interpretation:

4. **Malarial parasite (Peripheral smear/ card test)**

Patient preparation:

Sample collection:

Type of investigation:

Indication:

Interpretation:

5. **Dengue NS 1 – IgG, IgM (Card test)**

Patient preparation:

Sample collection:

Type of investigation:

Indication:

Interpretation:

(Add additional page if required)

Teacher's signature

ROGA NIDAN EVAM VIKRITI VIGYAN ACTIVITY BOOK

SERIAL NO: 7 CLINICAL NO: C 7.10

Male infertility evaluation – ABC (32 years) presents with a complaint of difficulty in conceiving a child with his partner despite trying for more than a year. He and his partner have been engaging in regular unprotected sexual intercourse without any success. ABC reports no prior history of fertility issues or significant medical conditions. He denies any recent infections, surgeries, or exposure to environmental toxins. His partner has undergone a thorough gynecological evaluation and has been deemed medically fit for conception.

Initial Physical Examination:

- General appearance: No apparent abnormalities
- Vital signs: Blood pressure 120/80 mmHg, pulse rate 80 bpm, respiratory rate 16 breaths per minute, temperature 98.6°F (37°C)
- External genital examination: Normal appearance of the penis, scrotum, and testes

List of Tests for Male Infertility Evaluation:

Preliminary tests:

1. Semen Analysis: Assess the quantity, quality, and motility of sperm. Parameters evaluated include sperm count, motility, morphology (shape), and presence of any abnormalities or infections.

Further investigation:

2. Hormonal Profile: Testosterone, Follicle-Stimulating Hormone (FSH), Luteinizing Hormone (LH), Prolactin
3. Ultrasound Imaging (Scrotal)
4. Post-Ejaculatory Urinalysis

Mention the patient preparation, sample collection, type of investigation, indication, and interpretation of Sl. No 1

Materials required: Format to fill, Laboratory methods/ Clinical pathology textbooks if required.

1. **Semen Analysis: Assess the quantity, quality, and motility of sperm. Parameters evaluated include sperm count, motility, morphology (shape), and presence of any abnormalities or infections**

   Patient preparation:

   Sample collection:

   Type of investigation:

   Indication:

   Interpretation:

(Add additional page if required)

Teacher's signature

ROGA NIDAN EVAM VIKRITI VIGYAN ACTIVITY BOOK

SERIAL NO: 7 CLINICAL NO: C 7.11

Helminthiasis evaluation – XYZ (35 years) presents to the clinic with complaints of persistent abdominal pain, nausea, and weight loss over the past month. He also mentions noticing worms in his stool. XYZ has no significant medical history and has never experienced similar symptoms before.

Initial Physical Examination:

Upon examination, the physician notices mild tenderness in the right lower quadrant of the abdomen. There are no other remarkable findings on physical examination

List of Tests for Ascariasis Evaluation:

Preliminary tests:

1. Stool Examination: (Colour, Consistency. Microscopy - Ova , Cyst, Pus

cells)Further investigation:

2. Complete Blood Count (CBC)
3. Imaging Studies (CT scan)

Mention the patient preparation, sample collection, type of investigation, indication, and interpretation of Sl. No 1

Materials required: Format to fill, Laboratory methods/ Clinical pathology textbooks if required.

1. **Stool Examination: (Colour, Consistency. Microscopy - Ova , Cyst, Pus cells)**

   Patient preparation:

Sample collection:

Type of investigation:

Indication:

Interpretation:

(Add additional page if required)

Teacher's signature

ROGA NIDAN EVAM VIKRITI VIGYAN ACTIVITY BOOK

SERIAL NO: 8 CLINICAL NO: C 8.1

1. **Activity Name**

   X-Ray reading (Basics – Positioning, etc.)

2. **Activity Description:**

   Evaluate chest X-Ray for positioning, rotation, and penetration.

3. **Materials and Equipment:**

   Format to fill, Books related to radiology if required, X Ray films.

4. **Basics of X Ray:**

Positioning:

Rotation:

Penetration:

Any other observations:

Write your inference on the given X-Ray:

Teacher's signature

ROGA NIDAN EVAM VIKRITI VIGYAN ACTIVITY BOOK

SERIAL NO: 8 CLINICAL NO: C 8.2

1. **Activity Name**

   X-Ray reading and interpretation (Chest)

2. **Activity Description:**

   Evaluate chest X-Ray for Airway and tracheobronchial tree, Bones and Bony Structures, Cardiac Silhouette, Diaphragm, Effusions (Pleural), Fields (Lung Fields), Gastric Bubble (Stomach), and Hilum. Write your comments on the given X-Ray.

3. **Materials and Equipment:**

   Format to fill, Books related to radiology if required, X Ray films.

4. **Chest X Ray:**

Airway and tracheobronchial tree:

Bones and Bony Structures:

Cardiac Silhouette:

Diaphragm:

Effusions (Pleural):

Fields (Lung Fields):

Gastric Bubble (Stomach):

Hilum:

Any other observations:

Write your inference on the given X-Ray:

Teacher's signature

ROGA NIDAN EVAM VIKRITI VIGYAN ACTIVITY BOOK

SERIAL NO: 8 CLINICAL NO: C 8.3

1. **Activity Name**

   X-Ray reading and interpretation (Bones and Joints)

2. **Activity Description:**

   Evaluate X-Ray for various bone and joints. Write your comments on the given X-Ray.

3. **Materials and Equipment:**

   Format to fill, Books related to radiology if required, X Ray films.

4. **Bones and joints X Ray:**

Study Details:

Imaging Modality: X-ray -

Body Part: (Specific bones or joints examined) -

Radiographic Views: (Specific views obtained) -

Technique: (Exposure details, if available) -

Findings:

List and describe the relevant bones or joints examined -

Provide a detailed description of the observed abnormalities, including fractures, dislocations, joint space narrowing, bone density changes, or any other significant findings -

Include measurements or quantitative details, if applicable -

Impression:

Provide a concise summary of the overall findings -

Mention any specific diagnosis, if possible -

Indicate the significance or clinical relevance of the observed abnormalities -

Recommend any additional imaging studies or consultations, if necessary -

Recommendations:

Suggest any further diagnostic steps or follow-up examinations -

Teacher’s signature

ROGA NIDAN EVAM VIKRITI VIGYAN ACTIVITY BOOK

SERIAL NO: 9 CLINICAL NO: C 9.1 & 9.2

1. **Activity Name**

   Basic ECG interpretation

2. **Activity Description:**

   Evaluate ECG for any abnormalities. Write your comments on the given ECG.

3. **Materials and Equipment:**

   Format to fill, Books related to ECG if required, ECG.

4. **ECG interpretation:**

ECG reporting:

ECG Technical Details:

A. ECG lead configuration (standard or modified) -
B. Paper speed (25 mm/s or 50 mm/s) -
C. Calibration (in millivolts per millimeter) -
D. Any artifacts or technical issues encountered during the recording -

Heart Rate and Rhythm:

A. Heart rate (calculated or measured) -
B. Rhythm interpretation (sinus rhythm, atrial fibrillation, etc.) -
C. Presence of any ectopic beats or arrhythmias -

P-Wave Analysis:

A. P-wave morphology (duration, amplitude, and shape) -
B. Presence of P-wave abnormalities (e.g., P-wave abnormalities indicating atrial enlargement) -

PR Interval:

A. PR interval duration -
B. Assessment of atrioventricular conduction -

QRS Complex:

A. QRS complex duration -
B. Assessment of ventricular conduction and morphology –

ST Segment:

A. ST segment morphology (elevation, depression, or isoelectric) -
B. Presence of ST segment abnormalities indicating myocardial ischemia or injury -

T-Wave Analysis:

A. T-wave morphology (symmetry, amplitude, and shape) -
B. Presence of T-wave abnormalities (inversion, flattening, or peaked T-waves) -

QT Interval:

A. QT interval duration -
B. Assessment of QT interval prolongation -

Axis and Intervals:

A. Electrical axis of the heart (normal or deviated) -
B. Measurement of other intervals (e.g., PR, QRS, QTc) -

Additional Findings:

A. Any additional findings, such as ventricular hypertrophy, chamber enlargement, or ST-Twave abnormalities -

Clinical Impression:

A. Interpretation and overall impression of the ECG -
B. Differential diagnosis and possible clinical implications –

Recommendations:

A. Suggested follow-up or additional investigations, if necessary -

Teacher's signature

ROGA NIDAN EVAM VIKRITI VIGYAN ACTIVITY BOOK

SERIAL NO: 10 CLINICAL NO: 10.1 to 10.5

Write in detail the case of a patient with details furnished under specific headings (For subheadings and reporting refer previous activities)

1. **Patient information:**

Age:

Sex: M/ F/Others

Marital status:

Education:

Occupation:

Religion:

Socio-economic status:

Date of Consultation:

Outpatient Number:

Date of Admission:

In Patient Number:

Bed number:

Place of residence:

2. **Pradhana Vedana with Kala prakarsha (Chief complaints with duration):**

3. **Vedanasammuchraya (History of present illness):**

4. Poorvavyadhi Vruttanta (History of Past illness):

5. Chikitsa Vruttanta (Treatment history):

6. **Kula Vruttanta (Family history) Along with pedigree chart:**

7. **Samajika Vruttanta (Social history):**

8. Vayaktika Vruttanta (Personal history):

9. **General physical examination**:

10. **Systemic examination/ Srotopareeksha** (General systemic and Local systemic/ Examination of affected system):

11. Investigations (Available reports and suggested investigations):

12. Differential diagnosis/ Sapekshanidana:

13. Vyadhi vinischaya (Diagnosis):

14. Samprapti ghataka (Samprapti ghataka of the patient based on history taking and examination)**:**

Dosha: Shareerika

Vriddhi / Kshaya
Samsarga / Sannipata: Sama samsarga / sannipata Or Vishama samsarga / sannipata
Anubandha - Anubandhya -
Dosha bheda:
Gati: Urdhva / Adha / Tiryak; Shakha / Koshta / Marma asthi sandhi

Dosha: Manasika

Raja / Tama

Dushya: Write Vriddhi/ Kshaya/ Dushti of
Dhatu (Specify)
Upadhatu (Specify)
Mala (Specify)
Manas (Specify)
Indriya (Specify)
Avayava (Specify)

Srotas: Primary srotas (Specify)
Secondary srotas (Specify)

Sroto dushti lakshana: Primary sroto dushti (Specify)
Secondary sroto dushti (Specify)

Agni: Koshtagni: Sama / Vishama / Teekshna / Manda
Dhatwagni: Sama / Manda
Bhutagni: Sama / Manda

Ama: Koshtastha ama / Dhatugata ama / Malarupi ama / Dosharupi ama

Udbhava sthana: Amashaya / Pakvashaya

Vyakta sthana: Sarva dehika / Sthanika (Specify)
Bahya rogamarga / Madhyama rogamarga / Abhyantara rogamarga

15. **Sadhyasadhyata** (with rationality)

Teacher's signature