This is a sample, representative template, normally used in clinics. It can be fully customised as per requirement.



Doctor Name

MBBS, MD Cardiologist Your Hospital Name, Street Name, Locality, Area, City, State, Pincode: 100XXX

+91-98XXXXXXX1

myemailid@gmail.com

Patient Name :		Date :						
UHID No. :	Age / Gender :	Mob.:						
VITAL SIGNS (As Applic	able):							
BP (mm/Hg): Sys	/Pulse (/min):	Height (cms):						
Weight (kg):	Resp. Rate (/min):	Temp (C):						
PRESENTING COMPLA	INTS WITH DURATION / REASON FOR CONSULTATION:							
Chest Pain If Yes	Duration Reason Oedema Feet	If Yes Duration	Reason					
Dyspnea If Yes	Duration Reason Syncope	If Yes Duration	Reason					
Fatigue If Yes	Duration Reason Cough	If Yes Duration	Reason					
Palpitation If Yes	Duration Reason Intermittent Claudication / Extremely Pain	If Yes Duration	Reason					
Type of Pain:								
	aorta	PROVISIONAL DIAGN	IOSIS					
right coronary artery	left coronary artery circumflex branch of left coronary artery							

inferior vena cava

PREVIOUS INTERVEN	TION & DETAILS:									
Thrombolysis:										
CAG: Year	Findings:									
PCI: Year	Vessels:			St	ents:					
CABG: Year	Findings:									
ICD/CRT/PPI:										
Peripheral/Aorta/Intrave	nous:									
Others:										
LAB TESTS ADVI	SED: PREVIOUS F	FINDINGS:			LAB TESTS	ADVISED:	PREVIOUS FINDINGS:			
СВС					Ex. Stre	ss Echo				
Blood Sugar					Dob. St	ress Echo	ess Echo			
Lipid Profile					Holter N	lonitoring	onitoring			
Thyroid Profile					ABPM					
LFT			Chest X-F				Ray			
☐ KFT			ELR							
HbA1C			Urine A.C				C.R.			
ECG			☐ Vit D							
ТМТ										
Echo										
R _X										
Sr.	Medicine	Dose	Morn.	Noon	Night	Days	Special Instructions			
No.										
Follow Up Advice:			1	1	1	Nort V	icit			
i ollow op Advice:						Next V				
						DD	/ MM / YYYY			

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Patient Name:

Doctor Name

MBBS, MD Cardiologist Your Hospital Name, Street Name, Locality, Area, City, State, Pincode: 100XXX

Date:

+91-98XXXXXXX1

myemailid@gmail.com

UHID No. :	Age / Gender :		Mob.:				
Chief Complaints:							
ATT History:							
	Marata da		D		Dometica		
On Examination:	Medicine		Dose	N. 1.	Duration		
SPO2:		Morning	Noon	Night			
Pulse:							
B.P.: RS:							
CVS:							
P/A:							
Additional Finding:							
Investigations:							
☐ Chest X-Ray PA/AP View							
☐ CBC							
CRP							
RBS							
☐ Blood Sugar F							
☐ Blood Sugar PP							
D. Dimer							
HbA1C							
TSH							
Sputum for GeneXpertVit D3							
☐ Spirometry							
Others							
				I	I		

Please Rinse mouth after Inhaler and Nebulization. कृपया इनहेलर और नेबुलाइजेशन के बाद कुल्ला करें।

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Next Visit

DD / MM / YYYY



Doctor Name

MBBS, MD Cardiologist Your Hospital Name, Street Name, Locality, Area, City, State, Pincode: 100XXX

+91-98XXXXXXX1

myemailid@gmail.com

Patient Name :	UHID No	:
Date/Time :	Age/Gender: Mobile No	.:
LAB TESTS ADVISED:	Allergic to: Fall Risk Screening:	
Test 1	Nutritional Screening:	Pain Score (0-10):
Test 3	VITAL SIGNS (As applicable)	
Test 4	BP (mmHg): Sys / Dias Pulse (/min):	Temp (⁰F):
Test 5		
Test 6	Resp. Rate (/min): Weight (kg): Height (cm): _	BMI (kg/m²):
Test 7	CHIEF COMPLAINTS & HISTORY:	
Test 8	DM Y N HTN Y N Family H/o: Pr. H.D. / S.C.D. Y	N SA M (S1) D1
Test 9		Convs LA S2
Test 10	Dyslipidemia Y N NK	RCA RV OM-1 D2
Test 11		AM Cx OM-2
Test 12		PD
Other Lab Tests		
IMAGING TESTS ADVISED:	CLINICAL EXAMINATION:	
Test 1		
Test 2		
Test 3		
Test 4		
Test 5		
Test 6		
Test 7		
Test 8	DIAGNOSIS:	
Test 9		
Test 10		
Test 11		
Test 12		
Other Imaging Tests		



TREATMENT:										
Admis	sion Advised:	If yes								
Proced	lure Advised:	If yes								
Surger	y Advised:	If yes								
			PR	RESCRIPTIO	N					
Sr. No.		MEDICINE (WRITE IN CAPITAL)		Dose	Route	Frequency	Days	Any Special Instructions		
PLAN:										
FOLLOW UP:										
				Acut	е		FOLLOW UP DATE			
Doctor's Seal & Signature			Chronic			DD / MM / YYYY				



Doctor Name

MBBS, MD Cardiologist Your Hospital Name, Street Name, Locality, Area, City, State, Pincode: 100XXX

+91-98XXXXXXX1

myemailid@gmail.com

Patient Name :	UHID No :						
Date/Time :	Age/Gender: Mobile No. :						
LAB TESTS ADVISED:	Heightcms WeightKg BMITempF						
Test 1	Pulse /min B.P. mmHg Pain Score (0-10)						
Test 2	Fall Risk: Yes No Nutritional Status: Adequate Inadequate Allergy:						
Test 3	PRESENTING COMPLAINTS WITH DURATION:						
Test 4	Chest Pain If Yes Duration Oedema Feet If Yes Duration						
Test 5	Dyspnea If Yes Duration Syncope If Yes Duration						
Test 6	NYHA If Yes Duration Cough If Yes Duration						
Test 7	Fatigue If Yes Duration Intermittent Claudication / Extremely Pain If Yes Duration						
Test 8	Palpitation If Yes Duration Type of Pain: Typical Angina Atypical Angina Non Anginal Pain						
Test 9							
Test 10							
Test 11							
Test 12	DICK FACTOR PROFILE						
	RISK FACTOR PROFILE						
	Family History HTN DM Dyslipid CKD COPD Alcohol Hypo-Thyroid Smoking OSA Obesity Other						
Other Lab Tests							
	PAST HISTORY:						
IMAGING TESTS ADVISED:	Rheumatic Fever If Yes On Rheumatic Propylaxis Prior IHD If Yes Prior CAG/Intervention If Yes						
Test 1	Prior Cardiac Surgery If Yes Other (Specify): If Yes						
Test 2	Details:						
Test 3							
Test 4							
Test 5							
Test 6							
Test 7	PREVIOUS INTERVENTION & DETAILS:						
Test 8	Thrombolysis:						
Test 9	CAG: Year Findings:						
Test 10	PCI: Year Vessels: Stents:						
	CABG: Year Findings:						
Test 11							
Test 12							
	ICD/CRT/PPI:						
Other Imaging Tests	Peripheral/Aorta/Intravenous:						
	Others:						



Radiology Investigations:				VALUATION:	¬					
X-Ray			Rhythm		BMI	∐ HR		(R) SpO2		
	T			Pallor		JVP	Ede	ema	Ascites	
_				CVS:						
	4RI									
				D						
_ 	Sonography			Respiratory S	ystem:					
	onography									
_										
Periph	eral Pulses	Right	Left	Fundus Exam	ination:					
	d Bruit	Right	Left							
Radial		Right	Left	DDOVISION	AL DIAGNOSIS	2.				
Brachi	ial	Right	Left	FROVISION	AL DIAGNOSI.					
Femor	ral	Right	Left							
				FOLLOWUP	/ ADVICE:					
Poplite	eal	Right	Left							
DIP	_	Right	Left							
PT	_	Right	Left							
Gangr	ene	Right	Left							
					PRESCRIPTIO	N				
			DIONE		PRESCRIPTIO	14				
Sr. No.	MEDICINE (WRITE IN CAPITAL)				Dose	Route	Frequency	Days	Any Special Instructions	
Admis	sion Advised:	If yes								
Duca	lumo Advisa di	lf ve -								
rroce0	lure Advised:	If yes								
Surger	y Advised:	If yes								
					Acut	re		FOL	LOW UP DATE	
Do	Doctor's Seal & Signature				Acut			/	/	
		9			Chronic				DD / MM / YYYY	

