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 Applicable):

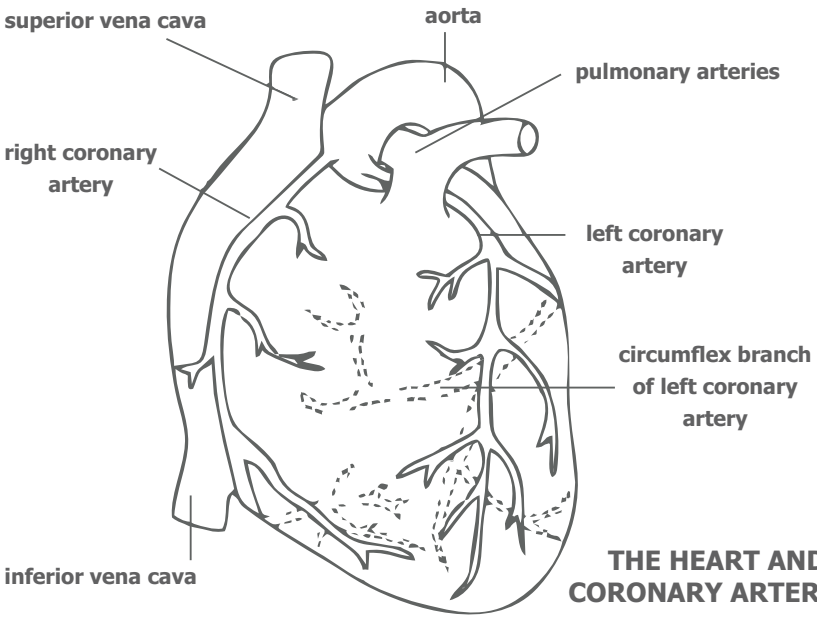
BP (mm/Hg): Sys _____ / _____ Dias Pulse (/min): _____ Height (cms): _____

Weight (kg): _____ Resp. Rate (/min): _____ Temp (℃): _____

PRESENTING COMPLAINTS 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: Typical Angina | Atypical Angina | Non Anginal Pain



THE HEART AND CORONARY ARTERIES

PROVISIONAL DIAGNOSIS

PREVIOUS INTERVENTION & DETAILS:

Thrombolysis: _____

CAG: Year Findings: _____

PCI: Year Vessels: _____ Stents: _____

CABG: Year Findings: _____

ICD/CRT/PPI: _____

Peripheral/Aorta/Intravenous: _____

Others: _____

LAB TESTS ADVISED:	PREVIOUS FINDINGS:	LAB TESTS ADVISED:	PREVIOUS FINDINGS:
☐ CBC		☐ Ex. Stress Echo	
☐ Blood Sugar		☐ Dob. Stress Echo	
☐ Lipid Profile		☐ Holter Monitoring	
☐ Thyroid Profile		☐ ABPM	
☐ LFT		☐ Chest X-Ray	
☐ KFT		☐ ELR	
☐ HbA1C		☐ Urine A.C.R.	
☐ ECG		☐ Vit D	
☐ TMT		☐ _____	
☐ Echo		☐ _____	

℞

Sr. No.	Medicine	Dose	Morn.	Noon	Night	Days	Special Instructions

Follow Up Advice: _____

_____

_____

Next Visit

DD / MM / YYYY

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Doctor Name

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Cardiologist

Your Hospital Name, Street Name,
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Patient Name : **Date :**

UHID No. : **Age / Gender :** **Mob. :**

Chief Complaints:

ATT History:

On Examination:

SPO2:
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 GeneXpert
- ☐ Vit D3
- ☐ Spirometry
- ☐ Others _____

_____
_____

Medicine	Dose			Duration
	Morning	Noon	Night	

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

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:

- [ ] Test 1
- [ ] Test 2
- [ ] Test 3
- [ ] Test 4
- [ ] Test 5
- [ ] Test 6
- [ ] Test 7
- [ ] Test 8
- [ ] Test 9
- [ ] Test 10
- [ ] Test 11
- [ ] Test 12

Other Lab Tests

IMAGING TESTS ADVISED:

- [ ] Test 1
- [ ] Test 2
- [ ] Test 3
- [ ] Test 4
- [ ] Test 5
- [ ] Test 6
- [ ] Test 7
- [ ] Test 8
- [ ] Test 9
- [ ] Test 10
- [ ] Test 11
- [ ] Test 12

Other Imaging Tests

Allergic to: _____ Fall Risk Screening: _____

Nutritional Screening: _____ Pain Score (0-10): _____

VITAL SIGNS (As applicable)

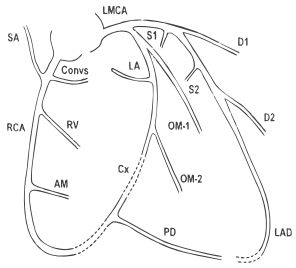
BP (mmHg): Sys _____ / Dias _____ Pulse (/min): _____ Temp (^{0}F): _____

Resp. Rate (/min): _____ Weight (kg): _____ Height (cm): _____ BMI (kg/m^2): _____

CHIEF COMPLAINTS & HISTORY:

DM [Y] [N] HTN [Y] [N] Family H/o: Pr. H.D. / S.C.D. [Y] [N]

Dyslipidemia [Y] [N] [N K] _____



CLINICAL EXAMINATION: _____

DIAGNOSIS: _____

TREATMENT:

Admission Advised: If yes

Procedure Advised: If yes

Surgery Advised: If yes

PRESCRIPTION

Sr. No.	MEDICINE (WRITE IN CAPITAL)	Dose	Route	Frequency	Days	Any Special Instructions

PLAN:

FOLLOW UP:

Doctor's Seal & Signature

Acute

Chronic

FOLLOW UP DATE

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:

- [ ] Test 1
- [ ] Test 2
- [ ] Test 3
- [ ] Test 4
- [ ] Test 5
- [ ] Test 6
- [ ] Test 7
- [ ] Test 8
- [ ] Test 9
- [ ] Test 10
- [ ] Test 11
- [ ] Test 12

Other Lab Tests

IMAGING TESTS ADVISED:

- [ ] Test 1
- [ ] Test 2
- [ ] Test 3
- [ ] Test 4
- [ ] Test 5
- [ ] Test 6
- [ ] Test 7
- [ ] Test 8
- [ ] Test 9
- [ ] Test 10
- [ ] Test 11
- [ ] Test 12

Other Imaging Tests

Height _____cms **Weight** _____Kg **BMI** _____ **Temp.** _____F

Pulse _____/min **R** _____/min **B.P.** _____mmHg **Pain Score** _____(0-10)

Fall Risk: ☐ Yes ☐ No **Nutritional Status:** ☐ Adequate ☐ Inadequate **Allergy:** _____

PRESENTING COMPLAINTS WITH DURATION:

Chest Pain	If Yes	Duration	Oedema Feet	If Yes	Duration
Dyspnea	If Yes	Duration	Syncope	If Yes	Duration
NYHA	If Yes	Duration	Cough	If Yes	Duration
Fatigue	If Yes	Duration	Intermittent Claudication / Extremely Pain	If Yes	Duration
Palpitation	If Yes	Duration			

Type of Pain: Typical Angina | Atypical Angina | Non Anginal Pain

RISK FACTOR PROFILE

☐ Family History ☐ HTN ☐ DM ☐ Dyslipid ☐ CKD ☐ COPD
☐ Alcohol ☐ Hypo-Thyroid ☐ Smoking ☐ OSA ☐ Obesity ☐ Other _____

PAST HISTORY:

Rheumatic Fever If Yes | On Rheumatic Propylaxis Prior IHD If Yes Prior CAG/Intervention If Yes

Prior Cardiac Surgery If Yes Other (Specify): If Yes _____

Details: _____

PREVIOUS INTERVENTION & DETAILS:

Thrombolysis: _____

CAG: Year Findings: _____

PCI: Year Vessels: _____ Stents: _____

CABG: Year Findings: _____

ICD/CRT/PPI: _____

Peripheral/Aorta/Intravenous: _____

Others: _____

Radiology Investigations:

- ☐ X-Ray _____
- ☐ CT _____
- ☐ MRI _____
- ☐ Sonography _____

	Right	Left
Peripheral Pulses		
Carotid Bruit		
Radial		
Brachial		
Femoral		
Popliteal		
DIP		
PT		
Gangrene		

CLINICAL EVALUATION:

☐ Rhythm ☐ BMI ☐ HR ☐ (R) SpO2

☐ Pallor ☐ JVP ☐ Edema ☐ Ascites

CVS: _____

Respiratory System: _____

Fundus Examination: _____

PROVISIONAL DIAGNOSIS: _____

FOLLOWUP / ADVICE: _____

PRESCRIPTION

Sr. No.	MEDICINE (WRITE IN CAPITAL)	Dose	Route	Frequency	Days	Any Special Instructions

Admission Advised: If yes _____

Procedure Advised: If yes _____

Surgery Advised: If yes _____

Doctor's Seal & Signature

Acute

Chronic

FOLLOW UP DATE

DD / MM / YYYY