



# Doctor Name

BDS, MDS  
Dental Surgeon

Your Hospital Name, Street Name,  
Locality, Area, City, State, Pincode: 100XXX  
+91-98XXXXXXX1  
myemailid@gmail.com

Patient Name :

Date :

UHID No. :

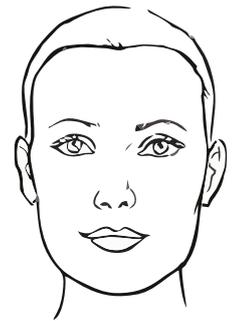
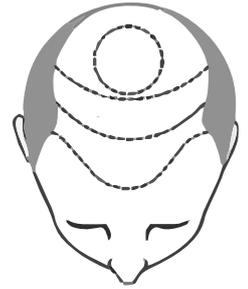
Age / Gender :

Mob.:

## < FACILITIES >



- Anti-Ageing
- Botox
- Chemical Peels
- Dermal Filler
- Dermaroller/  
Microneedling
- Dermoto Surgery
- Ear Lobe Repair
- Hair +/-
  - > PRP
  - > Stem Cell
  - > Intralesional Injections
- Nail Surgery
- Permanent Hair  
Reduction
- Scar Treatment
- Skin Lightening  
Procedures
- Surgery for  
Leucoderma
- Tattoo Removal
- Thread Lift
- Wart/Skin tag/  
Corn Removal



## NEXT VISIT

DD / MM / YYYY

Sr. No.:	Date	Work Done	Payment	Sign.



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Date :

UHID No. :

Age / Gender :

Mob.:

Major Illness: \_\_\_\_\_

BP:  Thyroid:  DM:

Personal History:  Married  Unmarried

Allergies:

### Advance Medical Therapy for

- Acne
- Scars
- Facial Rejuvenation
- Wrinkles
- Melasma
- Skin Lifting
- Skin Polishing
- Under Eye Dark Circles
- Warts & Mole Removal
- Derma Rollers
- Chemical Peels
- Hair Fall
- Dandruff
- Hair Thinning
- Alopecia
- PRP
- Unwanted Hair Removal
- Nutrition & Diet
- U Lipo
- Weight Loss Therapy
- Weight Gain Therapy
- Lasers
- Laser Carbon Peel
- Tattoo Removal
- Homeopathy

Please carry the prescription next time.

NEXT VISIT  
-----  
DD MM YYYY

NEXT VISIT  
-----  
DD MM YYYY

NEXT VISIT  
-----  
DD MM YYYY



# Doctor Name

MBBS, MD  
Dermatologist

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

### VITAL SIGNS:

Height(cms): \_\_\_\_\_ Weight(kg): \_\_\_\_\_ BMI: \_\_\_\_\_ BP(mm/Hg): \_\_\_\_\_

Pulse(/min): \_\_\_\_\_ Temp(°F): \_\_\_\_\_ Heart Rate: \_\_\_\_\_ BSA: \_\_\_\_\_

### CHIEF COMPLAINTS & HISTORY:

Itching:  1 week  1-2 week  2-4 week  >4 week

Rashes:  1 week  1-2 week  2-4 week  >4 week

Hair Loss:  1 month  1-3 months  3-6 months  >6 months

Pigmentation:  1 month  1-3 months  3-6 months  >6 months

Pimples:  1 month  1-3 months  3-6 months  >6 months

Burning sensation:  1 week  1-2 week  2-4 week  >4 week

Others: \_\_\_\_\_

RELEVANT PAST & FAMILY MEDICAL HISTORY: \_\_\_\_\_

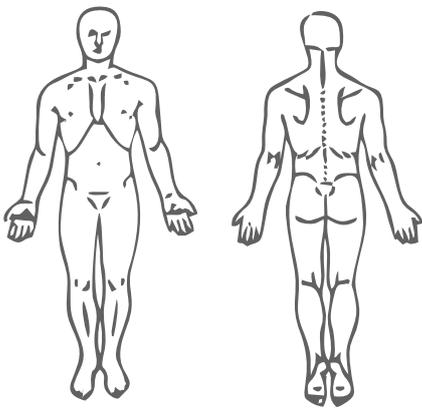
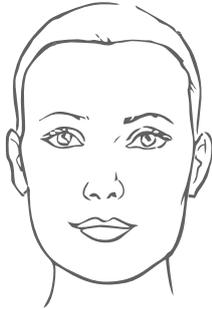
FAMILY HISTORY: \_\_\_\_\_

### GENERAL EXAMINATION:

Clubbing  Pallor  Icterus  Cyanosis

Level Of Consciousness: \_\_\_\_\_

Pedal Oedema: \_\_\_\_\_ Lymphadenopathy: \_\_\_\_\_



**SKIN EXAMINATION (System applicable):** \_\_\_\_\_

**1. Rash Type:**  Macule  Patch  Papule  Nodule

Cysh  Pustule  Blisters  Others

**2. Arrangements:**

In groups \_\_\_\_\_

Linear \_\_\_\_\_

Generalized \_\_\_\_\_

Dermatomal \_\_\_\_\_

Others \_\_\_\_\_

**PROVISIONAL DIAGNOSIS:** \_\_\_\_\_

**Admission Advised:**  If yes \_\_\_\_\_

**Procedure Advised:**  If yes \_\_\_\_\_

**PRESCRIPTION**

Sr. No.	MEDICINE (WRITE IN CAPITAL)	Dose	Morn	Noon	Night	Days

Doctor's Seal & Signature

Acute

Chronic

**FOLLOW UP DATE**  
DD / MM / YYYY



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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 (°F): \_\_\_\_\_

Resp. Rate (/min): \_\_\_\_\_ Weight (kg): \_\_\_\_\_ Height (cm): \_\_\_\_\_

### CHIEF COMPLAINTS & HISTORY:

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### PAST & FAMILY HISTORY:

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### SKIN EXAMINATION (System applicable):

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