Doctor Name

MBBS
ENT CONSULTANT & SURGEON

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

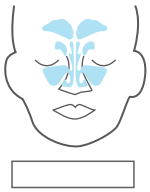
+91-98XXXXXXX1

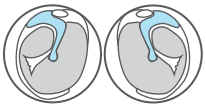
myemailid@gmail.com

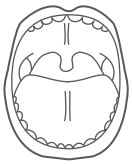
Patient Name : **Date :**

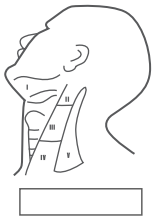
UHID No. : **Age / Gender :** **Mob. :**

On Examination:









H/O:

- ☐ Diabetes Mellitus
- ☐ Hypertension
- ☐ Bronchial Asthma
- ☐ Ototoxic Medications
- ☐ Noise Exposure
- ☐ Smoking/Alcohol/Tea/Coffee
- ☐ Allergy

Next Visit

DD / MM / YYYY

Next Visit

DD / MM / YYYY

Doctor Name

MBBS
ENT CONSULTANT & 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. :**

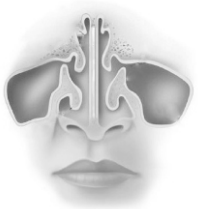
On Examination:

EAR: Right Left

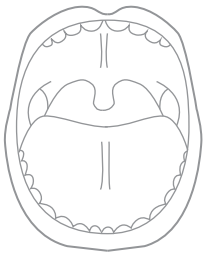
P:
M:
EAC:
TM:

Rinnes:
Webers:
ABC:

NOSE:



MOUTH:



IDL / VDL:

Next Visit

DD / MM / YYYY

Presumptive Diagnosis: _____

Next Visit

DD / MM / YYYY

Next Visit

DD / MM / YYYY

Doctor Name

MBBS, MD
ENT Consultant & Surgeon

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
- [ ] Test 13
- [ ] Test 14
- [ ] Test 15
- [ ] Test 16
- [ ] Test 17
- [ ] Test 18

Other Lab Tests

IMAGING TESTS ADVISED:

- [ ] Test 1
- [ ] Test 2
- [ ] Test 3
- [ ] Test 4
- [ ] Test 5
- [ ] Test 6
- [ ] Test 7
- [ ] Test 8

Consult. Start Time: _____ Allergic to: _____ Temp (°C): _____

Fall Risk Screening: _____ Nutri Screening: _____ (if applicable) Pain Score (0-10): _____

VITAL SIGNS (As applicable)

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

Weight (kg): _____ Resp. Rate (/min): _____ Head Circum-pediatric (cms): _____ (for paediatric only)

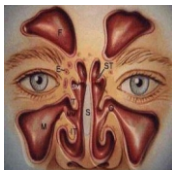
CHIEF COMPLAINTS & HISTORY:

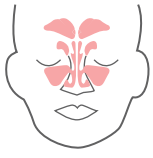
RELEVANT PAST MEDICAL HISTORY:

FAMILY HISTORY:

ON EXAMINATION:

Nose - Anterior Rhinoscopy:



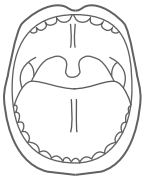


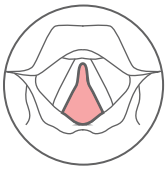
Throat - Oral Cavity:

Oropharynx:

Tonsils:

Indirect Laryngoscopy:





- [ ] Test 9
- [ ] Test 10
- [ ] Test 11
- [ ] Test 12
- [ ] Test 13
- [ ] Test 14
- [ ] Test 15
- [ ] Test 16
- [ ] Test 17
- [ ] Test 18
- [ ] Test 19
- [ ] Test 20
- [ ] Test 21
- [ ] Test 22
- [ ] Test 23
- [ ] Test 24

Other Imaging Tests

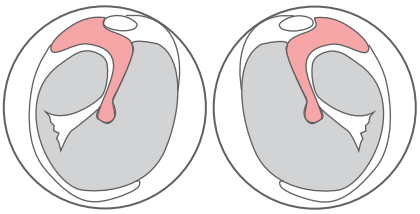
Ear:

RT Ear: EAC:

TM:

LT Ear: EAC:

TM:

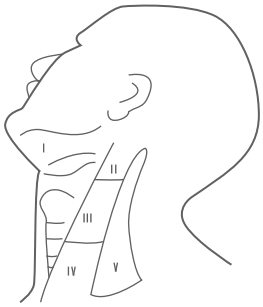


Tuning Fork Test:

Rinnies:

Webers:

ABC:



Neck:

Lymphadenopathy - [ ] Palpable

[ ] Not Palpable

PROVISIONAL DIAGNOSIS:

Admission Advised: If yes

Surgery Advised: If yes

TREATMENT

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

Doctor's Seal & Signature

Acute

Chronic

FOLLOW UP DATE

DD / MM / YYYY

Doctor Name

MBBS, MD
ENT Consultant & Surgeon

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.** :

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- [ ] 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(℉): _____ Heart Rate: _____ BSA: _____

CHIEF COMPLAINTS & HISTORY: _____

GENERAL COMPLAINTS:
- [ ] Fever
- [ ] Malaria
- [ ] Nauses
- [ ] Vomiting
- [ ] Weight Changes
- [ ] Others

RELEVANT PAST MEDICAL HISTORY:
- [ ] Diabetes
- [ ] Hypertension
- [ ] Bronchial / Asthma
- [ ] Jaundice
- [ ] IHD Pulmonary Tuberculosis
- [ ] Hypothyroidism

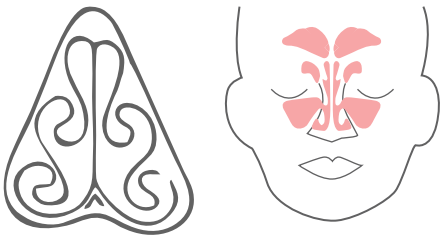
PREVIOUS SURGERY:
- [ ] Ear
- [ ] Nose
- [ ] Throat
- [ ] H/O Endotracheal Intubatin

PERSONAL HISTORY:
- [ ] Tobacco
- [ ] Alcohol
- [ ] Pan Chewing
- [ ] Diet & Habits
- [ ] Menstrual Periods

FAMILY HISTORY: _____

ON EXAMINATION:

Nose - Anterior Rhinoscopy:

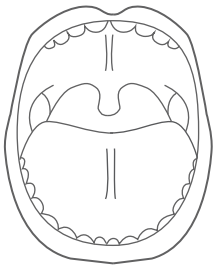


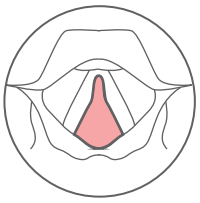
Throat - Oral Cavity:

Oropharynx:

Tonsils:

Indirect Laryngoscopy:





AUDIOLOGICAL INVESTIGATIONS:

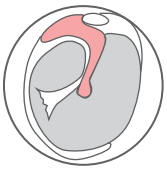
- ☐ Audiometry
- ☐ Impedance
- ☐ OAE
- ☐ BERA Test
- ☐ ASSR
- ☐ Video Laryngscopy
- ☐ Video Stroboscopy
- ☐ Diagnostic Sinuscopy

Ear:

RT Ear:

EAC:

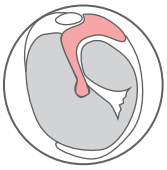
TM:



LT Ear:

EAC:

TM:



Tuning Fork Test:

Rinnies:

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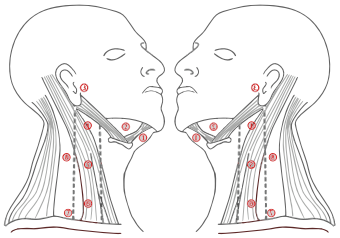
ABC:



Neck:

Lymphadenopathy -

- ☐ Palpable
- ☐ Not Palpable

PROVISIONAL DIAGNOSIS: _____

Admission Advised: If yes _____

Surgery Advised: If yes _____

1. _____
2. _____
3. _____
4. _____

PAC:

Financial Counselor:

TPA:

PRESCRIPTION

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

Doctor's Seal & Signature

Acute

Chronic

FOLLOW UP DATE

DD / MM / YYYY