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



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/0: Diabetes Mellitus
	[[[[Hypertension Bronchial Asthma Ototoxic Medications Noise Exposure Smoking/Alcohol/Tea/Coffee Allergy

Next Visit

DD / MM / YYYY

Next Visit

DD / MM / YYYY

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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/Gen	der: Mobi	le No. :
LAB TESTS ADVISED: Test 1			Temp (°C): Pain Score (0-10):
Test 2		(if applicable)	Paili Score (0-10).
Test 3	VITAL SIGNS (As applicable)		
Test 4	BP (mmHg): Sys	Dias Pulse (/min):	Height (cms):
Test 5	Weight (kg):R	esp. Rate (/min): He	ead Circum-pediatric (cms):
Test 6		(fo	r paediatric only)
Test 7	CHIEF COMPLAINTS & HIST	ORY:	
Test 8			
Test 9			
Test 10			
Test 11	RELEVANT PAST MEDICAL H	ISTORY:	
Test 12			
Test 13			
Test 14			
Test 15	FAMILY HISTORY:		
Test 16			
Test 17			
Test 18			
Other Lab Tests	ON EXAMINATION:		
	Nose - Anterior Rhinoscopy:		
	Trose varieties ramioscopy.		
IMAGING TESTS ADVISED:			
Test 1			
Test 2	Throat - Oral Cavity:		
Test 3	Oropharynx:		
Test 4	Tonsils:		
Test 5	Indirect Laryngoscopy:		
Test 6			
Test 7			
Test 8		Amad)	



		Ear:					
	Test 9	RT Ear:	EAC:		(8)		
	Test 10		TM:	/			
	Test 11					/ // \	
	Test 12	LT Ear:	EAC:				
	Test 13		TM:				
	Test 14	Tuning Fork Test:					
	Test 15	Rinnies:					
	Test 16	Webers:					
	Test 17	ABC:				(ك. الح	\
	Test 18	Neck:				\/	
	Test 19	Lymphadenopathy -	Palpable				
	Test 20		Not Delicate	Jo.		IV V	
	Test 21		Not Palpab	ne			
	Test 22	PROVISIONAL DIA	GNOSIS:				
	Test 23						
	Test 24						
	Other Imaging Tests	Admission Advised Surgery Advised:	: If yes				
			TREATMENT				
Sr. No.	MEDICINE (WRITE IN CAP	: ITAL)	Dose	Morn	Noon	Night	Days

Sr. No.	MEDICINE (WRITE IN CAPITAL)	Dose	Morn	Noon	Night	Days
Doctor's Seal & Signature		Acute		FOLLOW UP D		
		octor's Seal & Signature Chronic		DE) / MM / Y	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/Gend	er:	Mobile No. :	
LAB TESTS ADVISED: Test 1	VITAL SIGNS: Height(cms):\	Weight(kg):	BMI:	BP(mm/Hg):
Test 2 Test 3	Pulse(/min): 1	Гетр(F):	Heart Rate:	BSA:
Test 4 Test 5	CHIEF COMPLAINTS & H	ISTORY:		
Test 6 Test 7	GENERAL COMPLAINTS:	Fever	Malaria	Nauses
Test 8	RELEVANT PAST	Vomiting	Weight Changes Hypertension	Others Bronchial / Asthma
Test 10	MEDICAL HISTORY:	Jaundice	IHD Pulmonary Tuberculosis	Hypothyroidism
Test 11 Test 12	PREVIOUS SURGERY:	Ear H/O Endotracheal	Nose Intubatin	Throat
Other Lab Tests	PERSONAL HISTORY:	Tobacco Diet & Habits	Alcohol Menstrual Periods	Pan Chewing
IMAGING TESTS ADVISED:	FAMILY HISTORY:			
Test 1 Test 2	ON EXAMINATION:			
Test 3	Nose - Anterior Rhinoscopy:			
Test 5			(3)	
Test 6 Test 7)
Test 8 Test 9	Throat - Oral Cavity: Oropharynx:			
Test 10	Tonsils:			
Test 12	Traineet Euryngoso	- Line		
Other Imaging Tests				



AUDIOLOGICAL INVESTIGATIONS: Audiometry Impedance OAE BERA Test ASSR Video Laryngscopy Video Stroboscopy Diagnostic Sinuscopy	Ear: RT Ear: LT Ear: Tuning Fork Test: Rinnie Webee AB Neck: Lymphadenopathy	rs: BC:	EAC: TM: Palpable Not Palpable			
PROVISIONAL DIAGNOSIS:						
Admission Advised: If yes Surgery Advised: If yes 1						
		PRESCR	IPTION			
Sr. MEDICINE No. (WRITE IN CAPITA	AL)	Dose	Route	Frequency	Days	Any Special Instructions
Doctor's Seal & Signature			ncute			FOLLOW UP DATE DD / MM / YYYY