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

Doctor Name

MBBS
INTERNAL MEDICINE

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

+91-98XXXXXXX1

myemailid@gmail.com

Patient Name : **Date :**

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

D.O.B: DD / MM / YYYY **Height:** _____ **Weight:** _____ **Head Circumference:** _____

Purpose of Visit: ☐ Checkup ☐ Vaccination

Chief Complaints:

Signs & Symptoms:

- ☐ Fever
- ☐ Cough
- ☐ Cold
- ☐ Breathlessness
- ☐ Throat Pain
- ☐ Vomiting
- ☐ Loose Motion
- ☐ Constipation
- ☐ Tummy Pain
- ☐ Oral Ulcer / Complaint
- ☐ Urinary Complaint
- ☐ Rashes / Lesions
- ☐ Itching
- ☐ Injury
- ☐ Headache
- ☐ Insect Bite
- ☐ Eye Complaints
- ☐ Ear Complaints
- ☐ Scalp Complaints
- ☐ Loss of Consciousness
- ☐ Bleed
- ☐ Other

Probable Cause:

- ☐ URI
- ☐ Age
- ☐ Atopy
- ☐ UTI
- ☐ Pharyngitis
- ☐ FWF
- ☐ Growth Delay
- ☐ Breast Feeding Issue
- ☐ Bed Wetting
- ☐ Asthma
- ☐ Nutritional Issue
- ☐ Trauma Or Fall
- ☐ Celulitis / Abscess
- ☐ Other

Findings:

Advice:

Visit Doctor immediately if:
- Child not taking food
- Fast breathing
- Not passing urine 6 hourly
- Child excessively sleepy

Next Vaccine Name

_____

Date

DD / MM / YYYY

Prescription ℞

Sr. No.	MEDICINES	Days	DOSE			Morning	Afternoon	Evening	Night	Food	No. of Bottle / Tablets
			Drops	ML	TAB						
										Before	
										After	
										Before	
										After	
										Before	
										After	
										Before	
										After	
										Before	
										After	
										Before	
										After	
										Before	
										After	
										Before	
										After	

Next Visit

DD / MM / YYYY

Date: DD / MM / YYYY **Age:** _____ **Weight:** _____

Next Visit

DD / MM / YYYY

Doctor Name

MBBS
INTERNAL MEDICINE

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

+91-98XXXXXXX1

myemailid@gmail.com

Patient Name : **Date :**

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

P/H :

- ☐ Type 1 DM
- ☐ Type 2 DM
- ☐ Osteoarthritis
- ☐ Obesity
- ☐ HTN
- ☐ Dyslipidemia
- ☐ Neuropathy
- ☐ IHD
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Anaemia
- ☐ Other

Lab Investigations:

- ☐ CBC
- ☐ ESR
- ☐ HbA1C
- ☐ FBS
- ☐ PPBS
- ☐ LFT
- ☐ SGOT
- ☐ SGPT
- ☐ Renal Profile
- ☐ Sr. Ca
- ☐ Sr. Creatinine
- ☐ Sr. Uric Acid
- ☐ Lipid Profile
- ☐ ECG
- ☐ 2D Echo
- ☐ LDL
- ☐ USG
- ☐ T3, T4, TSH
- ☐ CRP
- ☐ TSH
- ☐ TPOAb
- ☐ RA Factor
- ☐ Anti CCP

Next Visit

DD / MM / YYYY

Treatment Adviced :

Sr. No.	Medicine	Morning	After Noon	Night	Dose (Duration)	Special Instructions

Next Visit

DD / MM / YYYY

Doctor Name

MBBS, MD
INTERNAL MEDICINE

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: _____ Pain Score (0-10): _____
(if applicable)

VITAL SIGNS (As applicable)

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

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

- [ ] Test 9
- [ ] Test 10
- [ ] Test 11
- [ ] Test 12
- [ ] Test 13
- [ ] Test 14
- [ ] Test 15
- [ ] Test 16
- [ ] Test 17
- [ ] Test 18

Other Imaging Tests

Admission Advised: If yes

Surgery Advised: If yes

PRESCRIPTION

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

Consultant Seal & Signature

Consultant Name: _____

FOLLOW UP DATE

DD / MM / YYYY

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Doctor Name

MBBS, MD
INTERNAL MEDICINE

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. :

VITAL SIGNS:

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

Pulse(/min): _____ Temp(℉): _____ Heart Rate: _____ BSA: _____

CHIEF COMPLAINTS & HISTORY:

LAB TESTS ADVISED:

- ☐ Test 1
- ☐ Test 2
- ☐ Test 3
- ☐ Test 4
- ☐ Test 5
- ☐ Test 6
- ☐ Test 7
- ☐ Test 8
- ☐ Test 9
- ☐ Test 10

Other Lab Tests

IMAGING ADVISED:

- ☐ Test 1
- ☐ Test 2
- ☐ Test 3
- ☐ Test 4
- ☐ Test 5
- ☐ Test 6
- ☐ Test 7
- ☐ Test 8
- ☐ Test 9
- ☐ Test 10

Other Imaging Tests

PROVISIONAL DIAGNOSIS:

Admission Advised: If yes

Surgery Advised: If yes

PRESCRIPTION

Sr. No.	DRUG NAME	Morning		Afternoon		Night		No. of Tablets
		Before Food	After Food	Before Food	After Food	Before Food	After Food	
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Doctor's Seal & Signature

Acute

Chronic

FOLLOW UP DATE

DD / MM / YYYY