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

doxper

Doctor Name

MBBS
NEUROLOGY

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

+91-98XXXXXXX1

myemailid@gmail.com

Patient Name : **Date :**

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

Pulse: ____________________ **BP:** ____________________

- [ ] **HTN**
- [ ] **DM**
- [ ] **Thyroid**
- [ ] **IHD**
- [ ] **Asthma**
- [ ] **Allergy**

ADVICE

Ophthalmology Opinion:

- [ ] Fundus
- [ ] Refraction
- [ ] IOP

Investigations:

Imaging:

- [ ] MRI
- [ ] CT Scan

Opinion / Referral:

Cranial -

- [ ] Headache
- [ ] Head Injury
- [ ] Brain Tumor
- [ ] Seizures
- [ ] Somantic
- [ ] Others

Spine -

- [ ] Degenerative Diseases
- [ ] Cervical
- [ ] Lumbar
- [ ] Dorsal
- [ ] Tumors
- [ ] Mechanical
- [ ] Pott's Spine
- [ ] **Peripheral Neuropathy**
- [ ] **Frozen Shoulders**
- [ ] Others

Next Visit

DD / MM / YYYY

Next Visit

DD / MM / YYYY

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NEUROLOGY

Your Hospital Name, Street Name,
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+91-98XXXXXXX1

myemailid@gmail.com

Patient Name : **Date :**

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

DM	HTN	Asthma	Thyroid	CAD	CKD	CLD	CVA	Viral Serology	Any Others

Chief Complaints:

Past: ____________________ **Family:** __________________ **Drug:** ___________________

Examination: **GPE:** **BP:**

Systemic: **Wt.:**

Neurology: **HMF:**

Cranial Nerves:

Motor: Inspection: Tone:

Power / Reflexes:	S	E	W	G	H	K	A	IM	B	T	S	K	A	P	S
Rt															
Lt															

Sensory:

Cerebellum: **Gait:**

Investigations: EEG:

ECG / Echo:

CT / MRI:

Others:

Next Visit

DD / MM / YYYY

Provisional Diagnosis:

Advice:

Medicines (Rx)	Breakfast ਸਵੇਰੇ		Lunch ਦੁਪਿਹਰੇ		Dinner ਰਾਤ		Others	
	Before ਪਿਹਲੇ	After ਬਾਅਦ	Before ਪਿਹਲੇ	After ਬਾਅਦ	Before ਪਿਹਲੇ	After ਬਾਅਦ		

Remarks:

Next Visit (Follow Up) / /

Time HH / MM AM PM

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

Doctor Name

MBBS, MD
Neurologist

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) (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
- [ ] Test 19
- [ ] Test 20
- [ ] Test 21
- [ ] Test 22

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

FOLLOW UP DATE

DD / MM / YYYY

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

Doctor Name

MBBS, MD
Neurologist

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. :**

History of Present Illness:

Medications
Current:

Has tried:

Allergies:
Past Medical:
Past Surgical:
Family History: ☐ Similar d/o
Social History: ☐ Tob ☐ Smk ☐ Etoh

Review of Symptoms (√ - Yes/Abnormality present, X - absent)

Neck/Back Pain:
Increased by:
☐ Turning over in bed
☐ Others:

☐ Dropping things
☐ Difficulty climbing stairs
☐ Slippers falling off

☐ Urinary Inc Freq
☐ Urinary urgency/incont
☐ Dysuria
☐ Bowel urgency/incont

☐ Unsteadiness
☐ Claudication __________feet

Dizziness:
Increased by:
☐ Getting up
☐ Turning over in bed
☐ Loud sounds
☐ Straining/lifting weights

☐ Relieved by lying down on: ___________

☐ Ear pain
☐ Ear discharge
☐ Ear fulness
☐ Decreased hearing
☐ Tinnitus

Visual Loss / Changes:
☐ Pain / Headache
☐ Diplopia
☐ Wt Loss / Myalgias
☐ s/o OSA

Dementia:
☐ Personality Changes
☐ Impulsivity, Sweet intake
☐ Calculation
☐ Multitasking
☐ Naming
☐ Short term memory
☐ Intermediate memory
☐ Long term memory
☐ Getting lost
☐ Problems using objects

☐ Hallucinations
☐ Day-to-day fluctuations
☐ Parkinsonism

Symptoms of:
☐ NPH
☐ OSA
☐ Depression
☐ Whipple's

Headache:
☐ Photophobia/phonophobia
☐ Nausea/Vomitting
☐ Frequency: ____________
☐ Ophtal eval __________ago
☐ Chronic Nasal stuffiness
☐ Dental Caries
☐ Cold intol/Wt Gain/Constip.
☐ Snoring
☐ Witnessed apneas
☐ Freq. visual obscuration
☐ Tinnitus
☐ h/0 CAD / Severe HTN /
☐ Stroke / Missed period

Syncope/Seizure:
☐ Ppting cause:

☐ Sounds becoming distant
☐ Tunnel vision
☐ Vasomotor Symptoms
☐ Pre-syncope
☐ h/o CP/Palpitations

☐ Staring spells _________/wk
☐ Isolated Aura _________/wk
☐ h/s/o nightime sz _____/wk
☐ Myoclonic jerks
☐ Others (Spasm/Tonic/Atonic)

☐ Birth problems
☐ Delayed Development
☐ Problems in school
☐ Febrile Sz:
☐ (temp, durn)
☐ Head Trauma
☐ Meningitis / Encephalitis
☐ Family h/o epilepsy

Sleep:
☐ Initiation insomnia
☐ Maintenance Insomnia
☐ EDS

☐ RLS / PLM / RBD
☐ Sleep Paralysis
☐ Cataplexy

☐ Depression / Anxiety
☐ Poor sleep hygiene
☐ OSA

Movement/Parkinsons:
☐ Present at rest
☐ While Writing/Buttoning
☐ Voice affected
☐ Reduced by Alcohol
☐ Increased by stress/coffe
☐ Sensory trick

☐ Slowness of movements
☐ Body stiffness
☐ C---A---R---D
☐ Falls _________after onset
☐ Freezing ______after onset
☐ Dysarthria/Dysphagia

☐ Urinary/Impotence/Sweat
☐ Myoclonus/Apraxia
☐ Early Dementia (FTD/DLB)

On Dopaminergic Therapy:
☐ Poor early AM Functioning
☐ Absent/Partial response
☐ Predictable OFF______hrs
☐ Unpredictable OFF

☐ ON-period freezing
☐ Peak dose dyskinesia
☐ Diphasic dyskinesia
☐ Refractor tremor

☐ Poor sleep quality
☐ OFF dystonia at night
☐ s/o orthostatic hypotension

☐ Exc. daytime sleepiness
☐ Impulsivity / Punding

Exam (√ - Normal/Present, Ø - absent)

General: ☐ Procerus Sign ☐ Hyperpig Knuckle ☐ Overweight - Short Neck

Mental Status:

Attention: | Abulia/Ashasia/Neglect/Apraxia: | /4 step command
Orientation: | /3 immediate recall
Processing Speech: | /3 delayed recall

Cranial Nerves

VA/VF: | Facial Symm: | Sq.W. jerks: | EOM:
Pupils: | Facial Sensation: | Pursuit:
Hearing: | Tongue Movements: | Saccades:
Dysarthria: | "Apraxia" of eye opening:

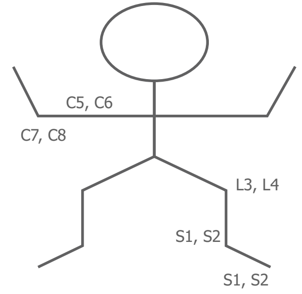
Motor

Drift: | Rigidity: | Finger/Foot tapping/wiggling
Hyperkinesias:

Gross Strength and Reflexes

Neck Flexion		Right	Left
C5Ax	Deltoid		
C56Mc	Biceps		
C7Ra	Triceps		
C8Me	FDPmid		
C8T1Me	APB		
C8T1Me	OP		
C8T1UI	ADM		

Neck Extension		Right	Left
L23Fe	Iliopsoas		
L45Dp	TA		
L45DpTi	Inversion (TA+TP)		
L5Dp	EHL		
L5S1Sp	Eversion (PL+PB)		
S1Ti	Gastrosol		
S1, S2Ti	ADQ-pedis		



Sensory

Upper Extremity: | Lower Extremity:

Gait

Unsupported rising: | Magnetism / Freezing:
Base: | Posture: | Arm Swing
Timed walk: | Pull test (2) | Romberg:

Other Tests

FNT / RAM / check: | SLR: | MMSE / MOCA:
H&Y Scale: | Roos / Spurling: | Dix-Hallpike:

Previous Investigations (Incl. MRI): ____________________

Assessment and Plan:

☐ Focal Epilepsy ☐ Generalised Epi ☐ IPD ☐ PSP ☐ Med-induced Parkinsonism ☐ Parkinsonism, not specified ☐ Other

Lab Investigations:

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

Other Lab Investigations

IMAGING ADVISED:

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

Other Imaging Investigations

Medicine Name (IN CAPITALS)	Dose	Morning	Noon	Night	Days

Admission Advised: If Yes

Procedure Advised: If Yes

Acute | Chronic

Doctor's Seal & Signature

FOLLOW UP DATE

DD / MM / YYYY