

doxper

Doctor Name

MBBS
ONCOLOGY

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

Patient Name :

Date :

UHID No. :

Age / Gender :

Mob.:

Wt.: _____

Ht.: _____

BSA _____



ER

PR

HER

AR

CEA

CA125

Mets

Chemo

Hormone

Surgery

Radiation

DM

HT

Ki67

Allergy

NEXT VISIT

DD MM YYYY

◆ Please Bring This Paper Every Visit ◆

“Patients can take any Generic Medicine as per availability and patient choice”



- Early
- Recurrent
- Metastatic

- AC
- CAF
- D
- TC
- H
- TCF
- FOLFOX
- Fulvetraz (250 mg)
- Fulvetraz (500 mg)

NEXT VISIT		
DD	MM	YYYY

NEXT VISIT		
DD	MM	YYYY

◆ Please Bring This Paper Every Visit ◆
"Patients can take any Generic Medicine as per availability and patient choice"



Doctor Name

MBBS
ONCOLOGY

Your Hospital Name, Street Name,
Locality, Area, City, State, Pincode: 100XXX
+91-98XXXXXXXX1
myemailid@gmail.com

Patient Name :

Date :

UHID No. :

Age / Gender :

Mob.:

Provisional Diagnosis: _____ **UHID No.:** _____

History:

H/o Medication:

HTN Diabetes Thyroid Disorder

Vital Signs:

BP (mmHg): ^{Sys} / ^{Dias} Pulse (/min): Temp(F)⁰:

Systemic Examination: _____

Abdomen:

P/R:

Treatment Plan

S. N.	MEDICINE (WRITE IN CAPITAL)	Dose	Morn	Noon	Night	Days	Instructions
							<input type="checkbox"/> Before Food <input type="checkbox"/> After Food
							<input type="checkbox"/> Before Food <input type="checkbox"/> After Food
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							<input type="checkbox"/> Before Food <input type="checkbox"/> After Food

Next Visit

DD / MM / YYYY

Next Visit

DD / MM / YYYY

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

VITAL SIGNS (As applicable)

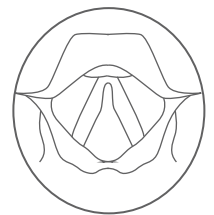
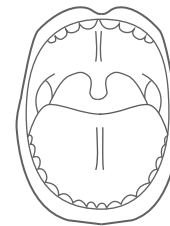
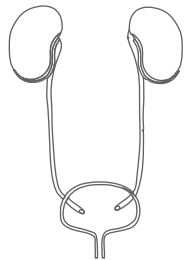
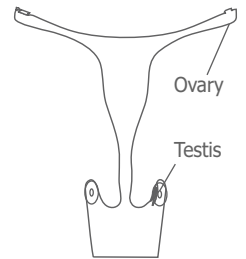
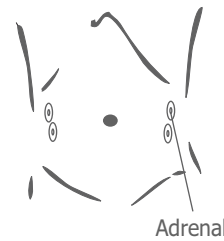
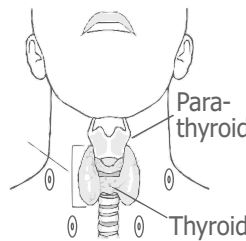
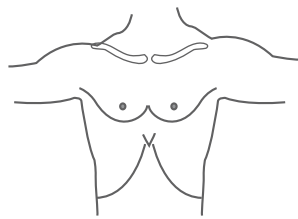
BP (mmHg): Sys _____ / _____ Dias _____ Pulse (/min): _____ Temp (°F): _____

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

Allergic to: _____ Fall Risk Screening: _____

Nutritional Screening: _____ Pain Score (0-10): _____

CHIEF COMPLAINTS & HISTORY:



RELEVANT PAST MEDICAL HISTORY:

FAMILY HISTORY:

OBSTETRICS / MENSTRUAL HISTORY:

- 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
- Test 25
- Test 26

Other Imaging Tests

GENERAL EXAMINATION:

Clubbing Pallor Icterus Cyanosis

Level Of Consciousness: _____

Pedal Oedema: _____ Lymphadenopathy: _____

SYSTEMIC EXAMINATION (System applicable):

CVS: _____

Respiratory System: _____

CNS: _____

Breast Exam. _____

Head & Neck _____

Abdomen _____

P/V _____

P/R _____

Supra. Lymph Nodes _____

Pulsation _____

Allen's test _____

PROVISIONAL DIAGNOSIS: _____

Admission Advised: If yes

Surgery Advised: If yes

PRESCRIPTION

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

Consultant Seal & Signature

FOLLOW UP DATE
 DD / MM / YYYY



Doctor Name

MBBS, MD
Oncologist

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

+91-98XXXXXXX1

myemailid@gmail.com

Patient Name :

UHID No :

Date/Time :

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LAB TESTS ADVISED:

- Test 1
- Test 2
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- Test 4
- Test 5
- Test 6
- Test 7
- Test 8
- Test 9
- Test 10
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- 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: _____ Pain Score (0-10): _____

Nutritional Screening : **Well Nourished** **Malnourished** Mild Moderate
 Severe Obese

VITAL SIGNS (As applicable)

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

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

PROVISIONAL DIAGNOSIS: _____

CHIEF COMPLAINTS & HISTORY: _____

RELEVANT PAST MEDICAL HISTORY: _____

- 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

STAGE: _____

Admission Advised: If yes _____

Surgery Advised: If yes _____

Chemotherapy: If yes _____

PRESCRIPTION

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

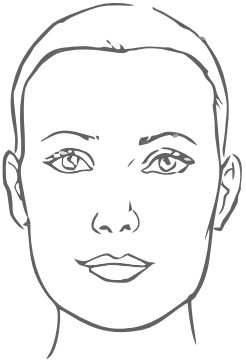
Doctor's Seal & Signature

FOLLOW UP DATE

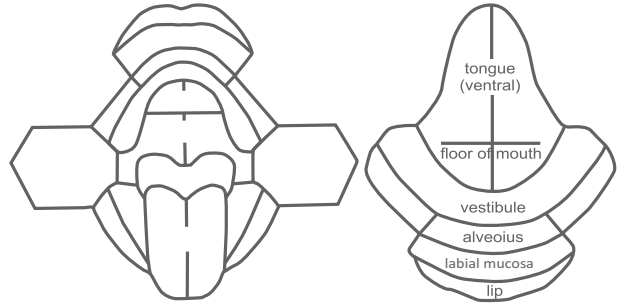
DD / MM / YYYY

CLINICAL FINDINGS

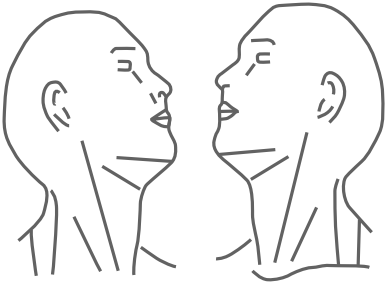
Face Frontal



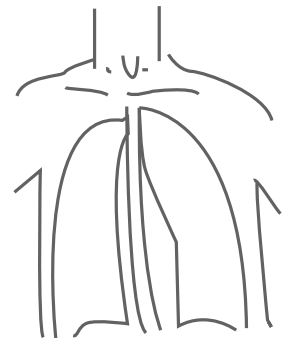
ORAL CAVITY



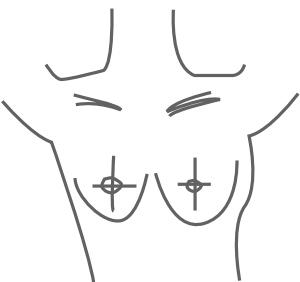
NECK

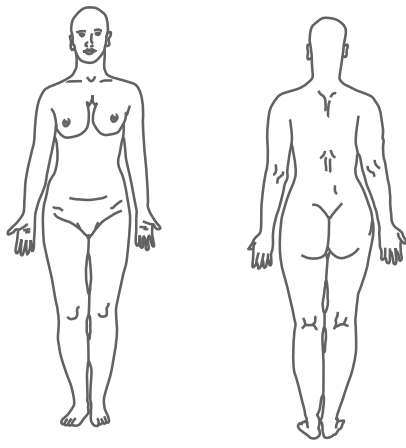


THORAX / LUNGS



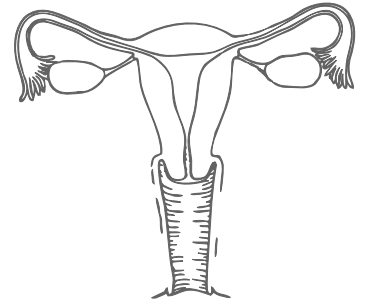
BREAST





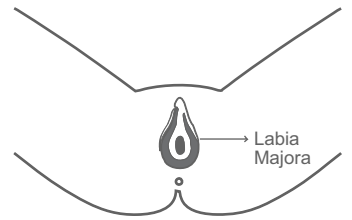
SKIN / BONE & SOFT TISSUE

FEMALE REPRODUCTIVE SYSTEM

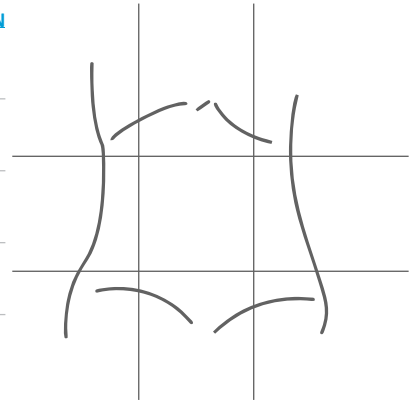


FEMALE REPRODUCTIVE SYSTEM





ABDOMEN



MALE REPRODUCTIVE SYSTEM



Doctor's Seal & Signature

FOLLOW UP DATE

DD / MM / YYYY