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

Doctor Name

MBBS
PAEDIATRICS

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.:.....Kgs
Ht.:.....Cms
HC:.....Cms
B.Wt.:.....Kgs

Diet:

- ☐ Breast Feeding
- ☐ Weaning
- ☐ Normal Diet
- ☐ Gluten Free Diet
- ☐ Lactogen Free Diet

Development :
Normal / Delayed

Ailments

- ☐ PFT D D M M Y Y Y Y
- ☐ Celiac Disease
- ☐ Meningitis
- ☐ Rheumatic Disease
- ☐ PEM
- ☐ CHD
- ☐ TB
- ☐ Nephrotic Syndrome
- ☐ Brucella
- ☐ Malaria
- ☐ Dengue illness
- ☐ IDDM
- ☐ Seizure / Epilepsy
- ☐ Thyroid diorders

Not Valid for Medico Legal Purpose

- ☐ Hospital Admission

D D M M Y Y Y Y

A B C D E

Provisional Diagnosis:

℞

Next Visit

DD / MM / YYYY

Date: D D M M Y Y Y Y

Provisional Diagnosis:

Wt.:.....Kgs

Ht.:.....Cms

HC:.....Cms

B.Wt.:.....Kgs

Next Visit

DD / MM / YYYY

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myemailid@gmail.com

Patient Name : **Date :**

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

Development: ☐ Normal ☐ Abnormal **Diet:** ☐ Breast Feeding ☐ Formula ☐ Weaning ☐ Normal Diet Ht: _____

☐ O.P.D. ☐ Vaccine B.Wt: _____

- ☐ CBC — HB ..... / TLC ..... / PL .....
- ☐ CRP .....
- ☐ MP .....
- ☐ WIDAL .....
- ☐ S. Creatinine .....
- ☐ SGPT .....
- ☐ B. Sugar .....
- ☐ S. Cal. .....
- ☐ S. Bili — T ..... / D .....
- ☐ Vit. D .....
- ☐ T3 ..... ☐ T4.....
- ☐ TSH .....

- ☐ Urine R/E RBC .....
- ☐ WBC ..... Protein .....
- ☐ MT .....
- ☐ X-Ray Chest .....

यदि बच्चे को :-

1. सांस लेने में तकलीफ हो
2. घबराहट हो
3. दौरा आए
4. तेज बुखार हो
5. पेट दर्द, उल्टी ज्यादा हो
6. शरीर पर नीले या लाल चिक्ते हो
7. पेशाब कम आए

तो तुरंत डॉक्टर से संपर्क करें ।

C/O:

Examination:

Diagnosis:

℞

Vaccination Advised:	
BCG	
OPV / IPV	
DPT / DPaT	
Hib	
HBV	
Measles	
MMR	
C Pox	
HAV	
Typhoid	
Prevenar	
Influenza	
Rotavirus	
HPV	
Other	

Investigation Advised:

Next Visit On

DD / MM / YYYY

Next Vaccination On

DD / MM / YYYY

Next Visit On

DD / MM / YYYY

Next Vaccination On

DD / MM / YYYY

Doctor Name

MBBS, MD
Paediatrics

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

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

Consult. Start Time: _____ Allergic to: _____

Temp (°C): _____ Pain Score (0-10): _____ Weight: _____

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

VITAL SIGNS (As applicable)

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

Resp. Rate (/min): _____

CHIEF COMPLAINTS & HISTORY:

RELEVANT PAST MEDICAL HISTORY:

FAMILY HISTORY:

BIRTH HISTORY/IMMUNIZATION HISTORY (PEDIATRIC):

GROWTH AND DEVELOPMENT HISTORY:

GENERAL EXAMINATION:

☐ Pallor ☐ Edema ☐ Icterus ☐ Cyanosis

Level Of Consciousness: _____

Throat: _____ Lymphadenopathy: _____

SYSTEMIC EXAMINATION (System applicable):

CVS: _____

Respiratory System: _____

Abdomen: _____

CNS: _____

Any Other: _____

PROVISIONAL DIAGNOSIS: _____

ADVICE: _____

Admission Advised: If yes _____

Surgery Advised: If yes _____

PRESCRIPTION

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
Paediatrics

Your Hospital Name, Street Name,
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myemailid@gmail.com

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Mobile No. :

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- [ ] 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): _____ H/C: _____ BP(mm/Hg): _____

Pulse(/min): _____ Temp(^{0}F): _____ Heart Rate: _____ BSA: _____

CHIEF COMPLAINTS & HISTORY:

GENERAL EXAMINATION:

FAMILY HISTORY:

DEVELOPMENT HISTORY:

IMMUNIZATION HISTORY:

PROVISIONAL DIAGNOSIS:

TREATMENT PLAN:

Admission Advised: If yes

Surgery Advised: If yes

PRESCRIPTION

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

Doctor's Seal & Signature

Acute

Chronic

FOLLOW UP DATE

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

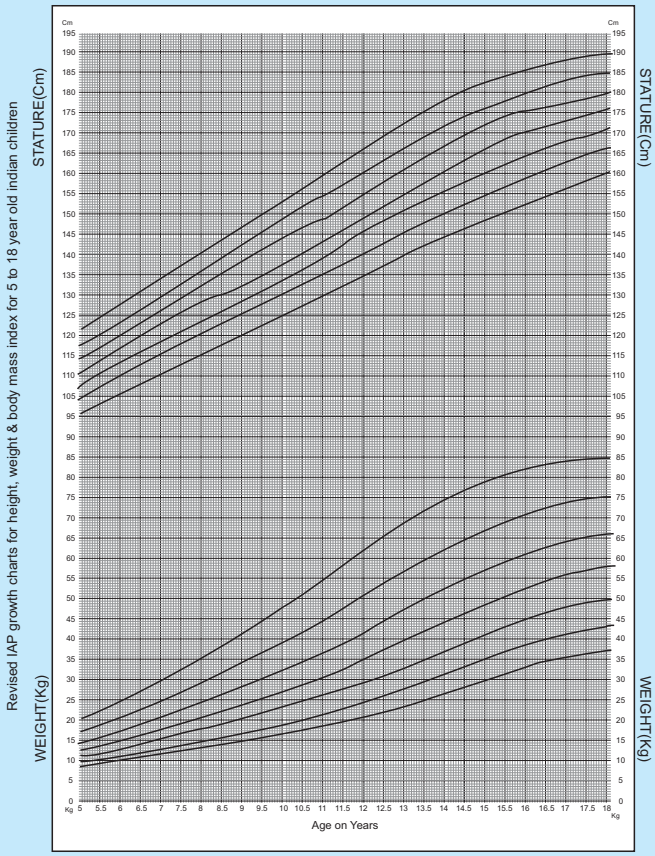
Age	Vaccines	Due on	Given on	Head Circumference	Height	Weight
Birth	BCG					
	OPV 0					
	Hep-B 1					
6 weeks	DTwP I/DTaP 1					
	IPV 1 / OPV1					
	Hep-B 2					
	Hib 1					
	Rotavirus 1					
	PCV 1					
10 weeks	DTwP 2/DTaP 2					
	IPV 2 / OPV2					
	Hib 2					
	Rotavirus 2					
	PCV 2					
14 weeks	DTwP 3/DTaP 3					
	IPV 3 / OPV3					
	Hib 3					
	Rotavirus 3					
	PCV 3					
6 months	OPV 4 & Hep-B 3					
	Influenza vaccine					
7 months	Influenza vaccine 2 (yearly)					
9 months	OPV 2					
	MMR 1					
9 to 12 months	Typhoid conjugate vaccine (TCV)					
12 months	Hep-A 1					
15 months	MMR 2 & Varicella 1					
16 months	PCV booster					
17 to 18 months	DTwP B1/DTaP B1 & Hib B1					
	IPV B1					
18 months	Hep-A 2					
2 years	Typhoid booster (TCV)					
	Meningococcal					
4 1/2 to 5 years	Dtwp B2/DTaP B2					
	OPV 3					
	MMR 3					
	Varicella 2					
10 to 12 years	Tdap/Td					
	HPV 1					
	HPV 2					

Next Visit DD / MM / YYYY

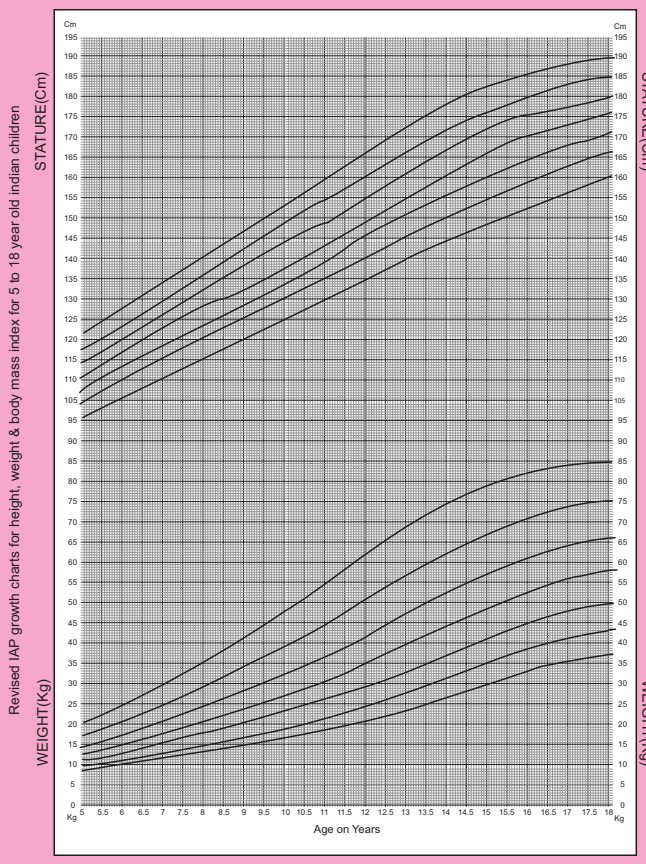
Next Visit DD / MM / YYYY

Next Visit DD / MM / YYYY

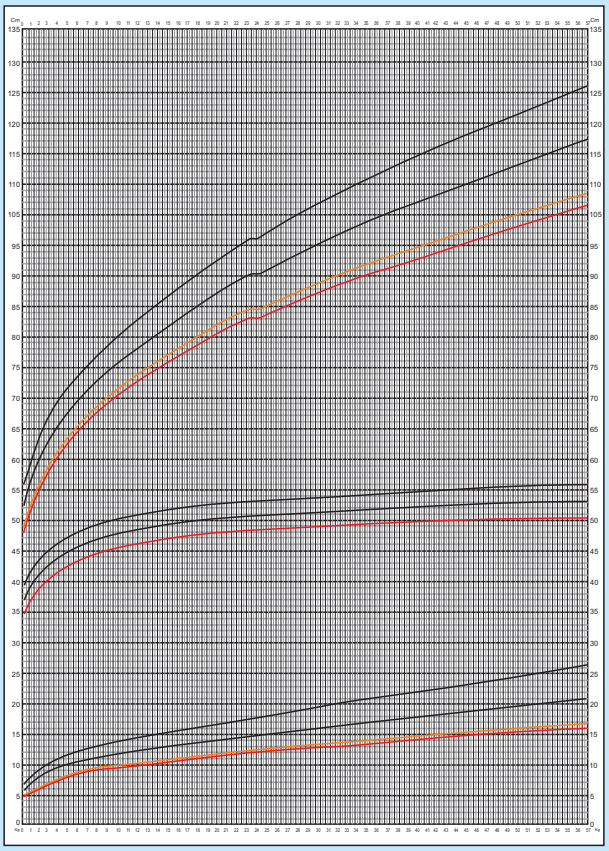
5 to 18 Year: IAP Boys Height and Weight Charts



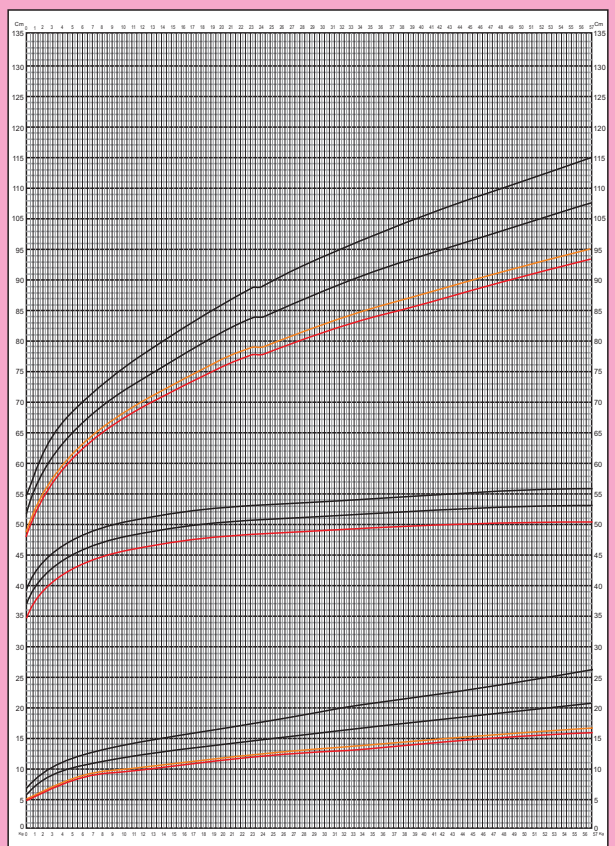
5 to 18 Year: IAP Girls Height and Weight Charts



WHO, Boys Height, Weight, Head Charts 0-5 years



WHO, Girl Height, Weight, Head Charts 0-5 years



Next Visit

DD / MM / YYYY

Next Visit

DD / MM / YYYY

Next Visit

DD / MM / YYYY

Next Visit

DD / MM / YYYY