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. :**

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
PSYCHIATRIST

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

+91-98XXXXXXX1

myemailid@gmail.com

Informant:_____ Precipitating Factor: _____

Address : _____ ID Proof :_____

History of Present Illness:

- [ ] Mood
- [ ] Idea/delusion
- [ ] OC Symptoms
- [ ] Suicidal Ideas
- [ ] Behavior
- [ ] Perception
- [ ] Sleep
- [ ] Appetite
- [ ] Bowel
- [ ] Bladder
- [ ] Cognitive Function
- [ ] Fits
- [ ] Sexual Problems

Substance Abuse:

- [ ] Alcohol
- [ ] Opiate
- [ ] Cannabis
- [ ] Tobacco
- [ ] BDZ
- [ ] Inhalants
- [ ] Cocaine
- [ ] Ecstasy

Development History:

Past History:

Family History / Family Tree:

Allergy:

Associated Medical / Surgical Illness:

Treatment History:

Mental Status Examination:

- [ ] Affect:
- [ ] Thought / Ideas:
- [ ] Perception:
- [ ] Cognition:
- [ ] Insight

General Physical Examination:

Investigation:

Diagnosis:

Treatment:

Doctor Name

MBBS, MD
Psychiatrist

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. :

INVESTIGATIONS 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 Test Advised

VITAL SIGNS (As applicable)

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

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

Allergic to: _____ Fall Risk Screening: _____

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

CHIEF COMPLAINTS & HISTORY:

PAST HISTORY:

STRESS FACTORS:

FAMILY HISTORY:

PERSONAL HISTORY, CLINICAL HISTORY:

RADIOLOGY INVESTIGATIONS ADVISED:

- [ ] USG Abdomen
- [ ] USG Pelvic
- [ ] USG Vascular
- [ ] MRI Head / Neck
- [ ] MRI Pelvic

Other Radiology Tests Advised

MENTAL STATE EXAMINATION (MSE):

PROVISIONAL DIAGNOSIS:

Admission Advised: If yes

PRESCRIPTION

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

FOLLOW UP DATE

DD / MM / YYYY

Consultant's Signature

Doctor Name

MBBS, MD
Psychiatrist

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.** :

Pulse (BPM) :		**Temp (°F)** :		**BP (mmHg)** :		**RR (cycle/min)** :	
Height (cms) :		**Weight (Kg)** :		**Saturation (%)**:		**BMI (kg/m²)** :	

COMPLAINTS:

SCREENING

PAIN:

FUNCTIONAL:

NUTRITIONAL:

DRUG ALLERGY:

PAST HISTORY (INCLUDING DRUG ALLERGIES):

PERSONAL/FAMILY HISTORY:

MENTAL STATE EXAMINATION (MSE):

Lab Investigations:

Radiology & Other Investigations:

- [ ] MRI
- [ ] CT
- [ ] USG
- [ ] X-Ray
- [ ] Other

Admission / Surgery / Day Care Procedures:

TREATMENT:

PRESCRIPTION

FOLLOW UP

Consultant Name & Signature