

IMAGE PLACEHOLDER

Date: \_\_\_\_\_

Patient's name	
Age	
OPD registration	

Sr.	Complaint	Duration

Vital Signs	Pulse (per minute):	Respiratory rate (per minute):
Vital Signs	Blood pressure (mm Hg):	Temperature:

Sr.	System	Findings

Sr.	Provisional Diagnosis	Investigations

Sr.	Dosage Form	Drug Name	Strength	Route	Frequency	Duration	Instruction

Other Instructions	
Next Follow-up	

Physician Signature	Stamp
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IMAGE PLACEHOLDER