# Patient Information System

**Patient Information ( precise )  
  
Personal Information**  
Patient Name\*  
Arrival Date [Auto]  
Contact Number\*  
Date of Birth\*  
 **Medical Information**  
Purpose of visit\*  
**DISEASE/CONDITION**

Diabetes  
High Blood Pressure  
Asthma  
High Cholesterol  
Hepatitis  
Depression  
Cancer  
Migraine Headaches  
Heart Disease  
Kidney Disease  
Stroke  
Other

Pulse  
BP  
Fever  
  
Prescribe Medicine  
 -Name

-Per day dose  
Suggested Test Recommend  
Total Cost  
blood pressure

Allergies

Medicines

**Personal Information**  
Patient Name\*  
Current Date [Auto]  
Date of Birth\*  
Gender\*  
Marital Status \*  
Occupation   
Contact Number\*  
City\*  
Address

**In Case of Emergency**  
Name   
Relation  
Contact Number

**Appointment Details**

Purpose of visit  
Current Date

Pulse  
BP  
Fever   
Symptoms   
Diagnosis  
Test Recommend  
**Previous Test Results**

* Test Name
* Remarks

Abstinence from:  
  
**Medicine Prescribed**

* Medicine Name
* Days to take
* Dosage

Next Appointment

**Medical History Information**  
  
**Patient figure**  
Height   
Weight  
 **Patient Medical Condition**

Anemia, Arthritis, Asthma ,Cancer, Kidney Disease  
  
Any Allergic Reactions?  
  
Previously taking any medicine (Name, Purpose)   
Any Surgeries Previously (Name, Date)  
  
Social History ( Smoking , Gutka , Alcohol , Pan Tobacco )  
Note  
  
Family Member History  
Relation Disease

**Patient History / Appointment**

Condition   
Diagnosis  
Abstinence from:   
Test Recommend  
**Test Reviewed**  
Test Name  
Test Consultation   
Treatment prescribed

Date of next appointment

Personal Medical Information

Review of Symptoms

Tobacco or drugs ?

**Existing Dedication**

Drugs  
Dosage   
Reason

Family Member History  
Relation   
Disease

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**Personal Information**  
Full Name   
Last Name  
Current Date  
Date of Birth/Age  
Gender  
Marital Status   
Occupation   
Mobile Number  
Home Number  
Email  
Province   
City  
Address

**In Case of Emergency**  
Name   
Relation  
Contact Number   
  
**Patient figure**  
Blood Group  
Height   
Weight

**Patient Condition**

Diabetic  
Allergic Reactions   
Note

**Patient History / Appointment**

Date  
Time  
Number   
Height   
Weight   
BMI  
Pulse  
BP  
Condition   
Diagnosis  
Abstinence from:   
Test Recommend  
**Test Reviewed**  
Test Name  
Test Consultation   
Treatment prescribed

Date of next appointment

Personal Medical Information

Review of Symptoms

Tobacco or drugs ?

**Existing Dedication**

Drugs  
Dosage   
Reason

Family Member History  
Relation   
Disease

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