Outpatient Visit & Diagnostic Record Form

Patient Details

Patient ID (Required, Text Only)
e.g. OPD-10245

Full Name (Required, Text Only)

Gender (Required, Choose One)
-- Select --

Age (Required, 0–120)

Contact Number (Required, 10 digits)
10-digit mobile number

Address (Optional)
Full residential address

Visit Details

Visit Date (Required)
mm/dd/yyyy

Visit Time (Optional)
--:-- --

Department (Required)
-- Select Department --

Consulting Doctor (Required)
Dr. Name

Visit Type (Required, Choose One)
○ First Visit ○ Follow-Up

Medical Evaluation

Chief Complaint (Required)

History of Present Illness (Optional)

Examination Findings (Optional)

Provisional Diagnosis (Required)

Final Diagnosis (Optional)

Diagnostic / Lab Tests Ordered

Tests Required (Optional, Check All That Apply)

- [ ] Complete Blood Count (CBC)
- [ ] X-Ray
- [ ] ECG
- [ ] Blood Sugar
- [ ] Urine Test
- [ ] CT Scan
- [ ] MRI

Other Tests (Optional, Text)

Specify other tests if any

Upload Existing Reports (Optional, PDF or Image)

Choose Files No file chosen

Prescription Details

Medicines Prescribed (Optional, Textarea)

Enter one medicine per line (Name - Dose - Frequency - Duration)

Dietary Advice (Optional, Textarea)

Any special diet instructions

Follow-Up Date (Optional)

mm/dd/yyyy

Doctor's Signature (Optional, Image)

Choose File No file chosen

Billing Information

Consultation Fee (Optional, Numeric ≥ 0)

Lab Charges (Optional, Numeric ≥ 0)

Total Amount (Auto Calculated, Readonly)

Payment Mode (Required)

○ Cash ○ Card ○ UPI

Transaction ID (Optional, Text)

Patient Consent & Declaration

I hereby declare that the information provided is true to the best of my knowledge.

☐ I agree and consent to treatment and data use for medical purposes. (Required)

Submit Record Clear Form