GOVERNMENT OF MEGHALAYA
HEALTH & FAMILY WELFARE DEPARTMENT

OUT PATIENT/DAY CARE CONSULTATION STANDARD MEDICAL SHEET

Hospital Name						District	
Patient's Name:						OPD/UHID No.	
Age:		Gender	M	F	O	Date of Reporting	
Father/Mother/Guardian Name for Minor						Date of Referral	
Address:						Place of Referral	
Occupation:						Contact No:	
Name of Consulting Doctor:							

1. Patient's Chief Complaint:

2. History of Present Illness:

3. Relevant and Significant Past History and Family History:

4. Physical Examination:

a) Body Vital Signs:

b) Systemic Body Review:

5. Provisional Diagnosis: _____

6. Laboratory/Investigation, if required

7. Final Diagnosis: _____

8. Rx and Advice:

9. Signature of the Consulting Medical Officer/Physician: _____

10. Date: _____