



STATE HEALTH SERVICES

MEDICAL SERVICES

Name: _____ Date: _____
 Address: _____
 Occupation: _____
 Age: _____ Sex: _____

Presenting Complaint: _____
 Duration: _____
 History of Present Illness: _____
 Past History: _____
 Family History: _____
 Social History: _____
 Physical Examination: _____
 Investigations: _____
 Diagnosis: _____
 Treatment: _____

Sl. No.	Particulars	Amount	Total	Remarks
1	Consultation Fee	2.00		
2	Investigation Fee	3.00		
3	Medicine	1.00		
4	Injection	1.00		
5	Operation	1.00		
6	Post-operative care	1.00		
7	Room & Board	1.00		
8	Transportation	1.00		
9	Other charges	1.00		
10	Total	12.00		

Signature of Doctor: _____
 Signature of Patient: _____
 Date: _____