**รายงานแพทย์ผู้ตรวจรักษา**

**Patient's Name………………………………………………………..………... Age:……..years Sex:** ☐ **male** ☐ **female**

**ID No……………………………………**

**H.N.#..................................A.N.#....................................X.N.#..................................**

**Date admitted…………………………………Time………… Date discharged…………………………………Time………….**

1. CHIEF COMPLAINT:

……………………………………………………………………………………………………………..

……………………………………………………………………………………………………………………………………

2. FOR ILLNESS

A. How long had the patient experienced the symptoms?………………..………………………………………..days/weeks/years

B. How long do you feel that the symptoms existed prior to this consultation?......................................................days/weeks/years

C. Did you advise the patent to be admitted to the hospital? ☐ No ☐ Yes

Indication for admission……………………………………………………………………………………………………….

3. FOR ACCIDENT

A. Date and time of accident: Date: ……………………………………………… Time: …………………………………………..

B. Cause of accident

…………………………………………………………………………………………………………..

C. Was the patient under the influence of alcohol or drug at the time of arrival to the hospital? ☐ No ☐ Yes…………...

4. Date first saw the patient for this illness / injury:

……………………………………………………………………………………..

5. a) Present illness / Details of injury:

…………………………………………………….……………………………….....

b) Pertinent clinical findings (symptoms & signs):

…………………………………………….…………………………...

6. a) Pertinent lab / Investigations:

……………………………………………………………………………………………………

b) HIV Test ☐ Yes, result……………………………………………………………………. ☐ No

7. Diagnosis 1 ……………………... ICD10 ☐☐☐☐☐ Diagnosis 2 ………………..………ICD10 ☐☐☐☐☐

Diagnosis 3 …………………….…CD10 ☐☐☐☐☐ Diagnosis 4 ………………...……ICD10 ☐☐☐☐☐

( Including principle underlying condition and complication )

8. a) Treatment ( Including number of stitches, medication given, physiotherapy, etc. ) :

………………………………………………………………………………………………………………..…………..

b) Operation…………...………………. ICD 9 ☐☐☐☐☐ Pathology report

…………………………………….…….

Surgeon's Name: ……………………………………… Specialty …………………….. Date performed

……………………

c) Diagnosis and treatment by others doctors in the same occasion ☐ No ☐ Yes, please give detail

……………………………………………………………………………………………………………………..…….

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9. a) Result of Treatment: ☐ Good ☐ Fair ☐ Poor

b) Possibility of recurrence? ☐ Yes ☐ No

10. a) Date of the last treatment / Follow up:

……………………………………………………………………………………………

b) The patient's symptoms at the time of last consultations / examination?

……………………………………………………...

11. Was the patient referred to you by others physician(s)? ☐ Yes ☐ No

Doctor: …………………………………………………Clinic / Hospital:

…………………………………………………….

12. Was the injury/illness contributed to or influenced by any of the following (Pre-existing weakness or extended period of disability)?

a) Physical defects / congenital anomaly ☐ No ☐ Yes

b) Unfavorable past medical history ☐ No ☐ Yes

c) Degenerative change(s) ☐ No ☐ Yes

d) A family history that increased the probability or severity of this disease ☐ No ☐ Yes

e) Doctor's advice to have periodic "Medical Screening" for this disease because of increased risk? ☐ No ☐ Yes

f) Alcohol or drugs = ……………. mg% ☐ No ☐ Yes

If the answer is "yes", please specify ☐ No ☐ Yes

………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………

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13. Other past medical history:

| Date | Diagnosis | Treatment | Duration | Doctor / Hospital's / Name |
|---|---|---|---|---|
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14. FOR FEMALE: Was the patient pregnant at the time of treatment ☐ No ☐ Yes.………. Wks (LMP ………..….)

: Was the treatment relate to infertility ☐ No ☐ Yes………………………………….

15. Other comments about the injury / illness

……………………………………………………………………………………………………………………………………

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**I, hereby certify that I have personally examined and treated the insured in connection to the above disability and that the facts are in my opinion as given above.**

**Name of physician ……………………………………………. Specialty …………………………. License No ………………...**

**Hospital Name ……………………………………………….. Address …………………………………. Tel. No ………………**

**Signature ………………………………………………………………. Date ……………………………………………………...**

**แพทย์ผู้ตรวจรักษาซึ่งออกรายงานฉบับนี้ ต้องเป็นแพทย์ปริญญาและมีใบอนุญาตประกอบโรคศิลป์**
**หากมีค่าธรรมเนียมผู้เอาประกันภัยเป็นผู้รับผิดชอบ**