DEPARTMENT OF IMMUNOLOGY

THE TAMIL NADU DR MGR MEDICAL UNIVERSITY

PROFORMA FOR PATIENTS SENT FOR LAB TEST

Name: **Ref. Physician:**

Age:

Sex:

IP/OP Number:

Address:

Contact Details:

Main Complaints and Duration:

Weight: **Height:**

Family History:

Siblings affected:

If Diabetic, Please fill in the following:

How long have you had Diabetes?

Occupation and economic status:

Habits: Alcohol intake Cig. Smoking Veg/Non-veg

Symptoms that prompted Diagnosis of Diabetes:

Present symptoms:

Glucose level: Fasting Urine Glucose

Treatment: Duration Any improvement perceived

Extent of Diabetic control

Provisional Diagnosis:

Known allergy to any food/ Medicine:

Investigations done:

Blood Tests: TC DC Peripheral smear

Biochemical tests:

Ultrasound findings:

Radiological findings:

Any other investigations:

Signature of the Asst Physician
Name :
Email :
Contact No: