

# Universal Medical Report Statement

## Patient Information

Full Name:

Date of Birth:

Gender:

Medical Record No.:

Contact Information:

Address:

## Physician/Facility Information

Physician Name:

Facility/Clinic Name:

Contact Number:

Address:

Date of Report:

## Clinical Statement

Chief Complaint:

History of Present Illness:

Relevant Medical History:

Allergies:

Medications:

## Examination & Investigation

Physical Examination

Findings:

Investigation/Lab Results:

Impressions/Working

Diagnosis:

## Management

Treatment Provided:

Medications Prescribed:

Procedures/Interventions:

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**Follow-up Plan:**

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## **Additional Notes**

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**Physician's Signature:**

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**Date:**

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