DEPARTMENT OF CLINICAL HEMATOLOGY
INITIAL ASSESSMENT SHEET

UHID: Name: Age/ Sex:	Date: Referred by: Dr. Occupation: Place:

History:Duration of illness

Family history/ Pedigree chart/ Siblings

Associated findings	Yes	No	Specify if yes
Fatigue:			
Fever:			
Bleeding:			
Malena:			
Jaundice:			
Joint Pain:			
Backache:			
Weight loss:			
Night sweats:			
Transfusions:			No: Last Tx:
Alt medicines/ Steroids:			
Comorbidities			DM: HTN: CAD: Seizures: Others:
Vegetarian			
Habits			Smoking Alcohol Others
Menstrual abnormalities			
Allergy			

Present medications:

Sl. No.	Name (Preferred)/ Brand	Dose	Route	Frequency
1.				
2.				
3.				
4.				

Previous investigations:

Date	Hb	MCV	TLC	Neutr	PL	Creat	Bil-T	Bili-D	SGPT	Prn-T	Alb

Peripheral smear: Date:

Date: PT (Test/Control in sec): APTT (Test/Control in sec):

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Others lab test reports/ Radiology investigations:

Examination:

Vitals:
Temperature:
Pulse:
SPO2:
BP:
RR:
Consciousness:

Respiratory System:
Breath sounds (Type and entry):
Added sounds:

Cardiovascular System:
Heart sounds:
Murmurs:

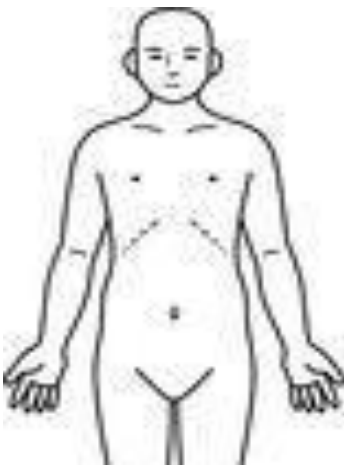
Per Abdomen:
Spleen: cm below SCM
Liver: cm below SCM

CNS:

Local examination:

Finding	Present	Absent
Pallor:		
Icterus:		
Edema:		
Lymphadenopathy:		
Platynychia:		
Clubbing:		
Knuckle hyperpigmentation:		
Cyanosis:		
Raised JVP:		
Purpura:		
Enlarged testis		
Sternal tenderness:		
Performance score:	/5	
Oral cavity:		

Pain score:



Provisional diagnosis:

Doctor's Sign and Name