Dr. [Doctor's Name]
Qualification: [Degrees]
Registration No.: [Registration Number]
Phone: [Contact Number]

[Clinic/Hospital Name]
[Address Line 1]
[Address Line 2]
[City, State, ZIP]

Patient Name: _____
Age/Gender: _____ / _____
Patient ID: _____

Date: _____
Time: _____

Medicine Name	Dose	Frequency	Duration	Instructions

Diagnosis / Chief Complaints:

Advice / Laboratory / Next Visit:

Doctor's Signature _____

Note: Please take medications as prescribed. In case of adverse reactions or persistent symptoms, consult your physician.