

Medical Report

Patient Name _____

DOB _____

Age _____

Nationality _____

Sex (*Gender*) _____

To Whomsoever It May Concern

This is to certify that Mr /Ms / Mrs _____
was diagnosed in _____
(insert the name of the Hospital / Clinic) on date _____

Blood Pressure _____

Pulse _____

Temperature _____

Skin _____

Conclusion _____

Doctor's name _____

Doctor's Signature _____

Doctor / Hospital / Clinic Stamp