



Laporan Perubatan (Medical Report)  
Kementerian Kesihatan Malaysia

KM/LP/2/2008



Jabatan : \_\_\_\_\_

**Butiran Pesakit (Patient Particulars):**

Nama pesakit (Name of patient) : .....

No K/P (I/C No): Baru (New) ..... Lama (Old) .....

No Passport (Passport No): ..... MRN: .....

Umur (Age): ..... Jantina (Sex) :  Lelaki (Male)  Perempuan (Female)

Tarikh masuk wad atau menerima rawatan buat kali pertama (Date of admission or receiving treatment for the first time): .....

Tempat menerima rawatan (Place where patient received treatment):

Jabatan Kecemasan (Emergency Department)

Klinik Pakar (Specialist Clinic)

Wad (Ward) .....

Tarikh discaj dari wad atau meninggal dunia (Date of discharge or death): .....

**Disiplin (*Discipline*):**

**Sejarah (*History*):**

*(Including Presenting Complaints, History of Presenting complaints, Past Medical History, Family History, Social History and Occupational History, Review of systems, Medical Records reviewed )*

**Pemeriksaan Fisikal (*Physical Examination*):**

*(Including general assessment, Eye, ENT, Oral Cavity, Respiratory System, Cardiovascular System, Abdomen, Genitourinary, Central Nervous System, Musculoskeletal, Mental Health Status and Others)*