



مركز أوركيذ الطبي
ORCHID MEDICAL CENTER

File No#: 1000250

Date: 5/3/2018

اسم المريض

Patient Name: Abdullah Ahmed

Date of Birth (تاريخ الميلاد): 20/9/1977 Gender (الجنس) (M) / F

Nationality (الجنسية): Saudi Occupation (الوظيفة): _____

Marital Status (الحالة الاجتماعية): _____ Phone No. (رقم الهاتف): 050-2390674

Contact Person in Case of Emergency: _____

How Did You Know About Us? Dr. Youssef

Weight: _____ Height: _____ Blood Type: _____

Chief Complaint: Abdominal pain for 3 days

السجل الطبي Medical History

Diseases: / Medication: /

Allergies: / Pregnancy: /

Hospitalization: / Family History: /

Habits: Smoking: Y/N Alcohol: Y/N Drugs: Y/N

Remarks: _____

Clinical Findings: chest clear, soft abdomen

Radiography: _____

Examination: /

Diagnosis: colitis ? food poisoning

1) Suspected infection

DOCTOR NOTE

