

# Student Biodata

**GR Number**

2335

**Date Of Birth**

2015-09-07

**Name**

AMAL ZEHRA

**Class**

4

**B-Form Number**

B Form Number

**Age**

9

**Gender**

Female

**School Name**

The SET School

**Contact Number**

Contact Number

Contact Number

**Emergency Contact Number**

03333991338

**Type Of Encounter**

Follow-up Case

# School Health Physician

## Medical History

### Chief Complaints

FOLLOW UP CASE OF LOW VISUAL ACUITY

### History of Presenting Complaints

PREVIOUS 6/9 B/L

### Review of Systems

DONE

### General

ALERT

### Eyes

R 6/24, L 6/9

### Ears, Nose and Throat

clear

### Teeth

N/A

### Cardiorespiratory

N/A

**Gastrointestinal**

N/A

**Genitourinary**

N/A

**Neuromuscular**

N/A

**Endocrine**

N/A

**Hematologic**

N/A

**Rheumatologic**

N/A

**Skin**

N/A

**Investigations / Laboratory Test Reports**

NON

**Medication History**

NON

**Allergies**

allergies

NON

**Past Medical History**

NON

**Past Surgical History**

non

**Birth History**

DONT KNOW

**Immunization History**

DONT KNOW

**Growth & Development / Puberty changes**

normal

**Nutrition History**

GOOD

**Family History**

NON

**Personal & Social History**

Drink mineral water

# PHYSICAL EXAMINATION

## Vital Signs and Measurements

Blood Pressure (Systolic) **Low**

100

Blood Pressure (Diastolic) **Low**

70

Temperature **Normal**

98.6

Pulse rate **Normal**

80

Respiratory Rate

15

Weight **Normal**

25

Height **Normal**

137

BMI **Low BMI**

13.32

## General Appearance

ALERT

## Skin

N/A

## Lymph Nodes

NORMAL

## Head

N/A

## Eyes

R 6/24, L 6/9

## ENT

CLEAR

## Chest

CLEAR

## Heart

CLEAR

## Abdomen

N/A

## Extremities

N / A

N/A

### **Neurologic Examination**

N/A

## **Diagnosis, Impression and Plan**

### **Problem List**

LOW VISUAL ACUITY

### **Impression**

LOW VISUAL ACUITY

### **Provisional Diagnosis**

H52.13-Myopia, bilateral

### **Investigations Recommended**

Select

### **General Advice & Management Plan**

NEED REVIEW WITH OPTOMETRIST

### **First Aid Given**

No

### **Follow-up Required**



No

## Refferrals

### Internal Referrals

### External Referrals

Optometrist

### Reason for Referral

LOW VISUAL ACUITY



