Comprehensive Health Assessment Form

Title: Comprehensive Health Assessment Form

Patient Information:

- **Full Name: _____**
- **Date of Birth: _____**
- **Age: _____**
- **Gender: [ ] Male [ ] Female [ ] Other**
- **Contact Information: _____**

Detailed Medical History:

- **Surgeries/Procedures: _____**
- **Chronic Conditions: _____**
- **Family Medical Background: _____**
- **Current Medications: _____**

Lifestyle and Habits:

- **Exercise Frequency: [ ] None [ ] 1-2 times/week [ ] 3-4 times/week [ ] Daily**
- **Diet Type: _____**
- **Smoking: [ ] Yes [ ] No**
- **Alcohol Consumption: [ ] Yes [ ] No**

Current Complaints and Symptoms:

Symptom	Severity (Mild/Moderate/Severe)	Duration	Comments
Fatigue			

Pain (specify area)			
Shortness of breath			
Nausea			
Dizziness			
Skin Rash			
Headache			
Fever			

Physician/Assessor Notes:

- **Observations: _____**
- **Assessment Summary: _____**
- **Recommendations/Next Steps: _____**

Physician's Name and Signature: _____

Date: _____