**Assessment Form for Patient**

### **Patient Information**

* **Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Patient ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Date of Assessment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Doctor/Nurse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### **Health Condition Assessment**

**☐ General Check-up  
☐ Follow-up Visit  
☐ Emergency Case  
☐ Specialist Consultation**

### **Vital Signs**

* **Blood Pressure: \_\_\_\_\_\_ / \_\_\_\_\_\_ mmHg**
* **Heart Rate: \_\_\_\_\_\_ bpm**
* **Respiratory Rate: \_\_\_\_\_\_ breaths per minute**
* **Temperature: \_\_\_\_\_\_ °F/°C**

### **Symptoms & Medical History**

| **Symptom** | **Present? (Yes/No)** | **Severity (Mild/Moderate/Severe)** |
| --- | --- | --- |
| **Pain/Discomfort** | **☐ Yes ☐ No** | **☐ Mild ☐ Moderate ☐ Severe** |
| **Fatigue** | **☐ Yes ☐ No** | **☐ Mild ☐ Moderate ☐ Severe** |
| **Fever** | **☐ Yes ☐ No** | **☐ Mild ☐ Moderate ☐ Severe** |
| **Dizziness** | **☐ Yes ☐ No** | **☐ Mild ☐ Moderate ☐ Severe** |

### **Diagnosis & Observations**

### **Treatment & Medication Plan**

**☐ Prescribed Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
☐ Lifestyle Changes Recommended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
☐ Follow-up Appointment Scheduled: ☐ Yes ☐ No | Date: \_\_\_\_\_\_\_\_\_\_\_\_**

### **Doctor’s Notes & Recommendations**

### **Patient’s Acknowledgment**

**☐ I understand my diagnosis and treatment plan.  
☐ I have received medical advice and instructions.**

**Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_  
Doctor’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**