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

Copyright @ SampleForms.com

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: ____________

Copyright @ SampleForms.com