Patient Medical Assessment Form

Patient Information

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

Medical History

- **Known Allergies: _____**
- **Current Medications: _____**
- **Past Surgeries or Illnesses: _____**
- **Family Medical History: _____**

Current Symptoms

- **Describe Symptoms:**

  _____
- **Duration of Symptoms: _____**
- **Severity: [ ] Mild [ ] Moderate [ ] Severe**

Vital Signs

- **Blood Pressure: _____**
- **Heart Rate: _____**
- **Temperature: _____**
- **Respiratory Rate: _____**

Physical Examination

- **Observations:**

  _____

- **Findings:**

  _____

Assessment and Diagnosis

- **Preliminary Diagnosis: _____**
- **Additional Tests Required: [ ] Yes [ ] No**
  - **If Yes, Specify: _____**

Recommendations

- **Treatment Plan:**

  _____

- **Medications Prescribed: _____**
- **Follow-Up Date: _____**

Physician's Details

- **Name: _____**
- **Signature: _____**
- **Date: _____**