Annual Health Check Up

PERSONAL INFORMATION

Name: _____ Age: _____

Date of birth: _____ dd / mm / yyyy Contact number: _____

Address

Emergency contact: _____ Contact number: _____

Medical history

Current medications

Allergies

Alcohol consumption

◯ Non-drinker ◯ Moderate drinker ◯ Heavy drinker

Smoking status

◯ Non-smoker ◯ Former smoker ◯ Current smoker

Physical activity

VITAL SIGNS

Systolic blood pressure: _____ mmHg: _____ Diastolic blood pressure: _____ mmHg: _____

Heart rate: _____ beats per minute: _____

Respiratory rate: _____ breaths per minute:

Temperature: _____ degrees Celsius/Fahrenheit:

PHYSICAL EXAMINATION

Height: _____ cm/inches: _____ Weight: _____ kg/pounds: _____

Body Mass Index: _____: _____ Waist circumference:: _____ inches/cm: _____

Others: _____: _____

Laboratory tests

Other findings

Recommendations

Additional notes