General Practice Intake

FIRST NAME: _____ LAST NAME: _____

D.O.B: _____ dd / mm / yyyy EMAIL: _____

SOURCE HISTORY (IF OTHER THAN PATIENT)

PRESENT COMPLAINTS:

HISTORY OF PRESENT ILLNESS:

PAST MEDICAL HISTORY:

PAST SURGERY HISTORY:

MEDICATIONS:

Allergies:

◯ Yes ◯ No

If yes, write your allergy

SOCIAL HISTORY

- ☐ SMOKING
- ☐ ALCOHOL CONSUMPTION
- ☐ DRUG ABUSE

FAMILY HISTORY

CIVIL STATUS *

- ◯ SINGLE
- ◯ MARRIED
- ◯ DIVORCED
- ◯ WIDOW(ER)
- ◯ RATHER NOT SAY

NUMBER OF CHILDREN: _____

WORK STATUS: *

◯ NO ◯ YES

IF YES PLEASE SPECIFY

PLEASE SELECT

- ☐ PREGNANT
- ☐ BREASTFEEDING
- ☐ NONE

VITAL SIGNS AND REVIEW OF SYSTEMS

Temp (c): _____ Pulse (bpm): _____

BP (mmHg): _____ Resp (/min): _____

Weight (kg): _____ BMI: _____

Other measurement (if any)

PHYSICAL EXAMINATION (MANDATORY):

Examination

Provisional Diagnosis:

Plan:

Outcome expected:

Doctor first name: *: _____ Doctor last name: *: _____

Doctor Signature: *