Health Assessment Form

Date of assessment: _____ dd / mm / yyyy

Patient details

Contact information: _____

Address: _____

Emergency contact person: _____

Emergency contact person's contact number:

Temperature: _____

Blood pressure: _____

Heart rate: _____

Respiratory rate: _____

SPO2: _____

Primary care provider: _____

Phone number: _____

Date of last medical consultation: _____ dd / mm / yyyy

Current medications

Allergies

Past medical history

- [ ] Diabetes
- [ ] Hypertension
- [ ] Asthma
- [ ] Heart Disease
- [ ] Other

Smoking status

- ◯ Never smoked
- ◯ Former smoker
- ◯ Current Smoker (packs/day)

Please specify: _____

Alcohol consumption

- ◯ None
- ◯ Occasional
- ◯ Regular (units/week)

Please specify

Exercise frequency

- ◯ Sedentary
- ◯ 1-2 times/week
- ◯ 3-4 times/week
- ◯ 5 or more times/week

Dietary habits

Current stressors

Mental health history

- ☐ Depression
- ☐ Anxiety
- ☐ PTSD
- ☐ Other

Current mental health support

- ◯ None
- ◯ Counseling/therapy
- ◯ Medication
- ◯ Support groups

Please specify: _____

Emotional well-being scale (1-10): _____

Suicidal thoughts or self-harm

- ◯ Yes
- ◯ No

If yes, please elaborate

General appearance - Results

- ◯ Not examined
- ◯ Normal
- ◯ Abnormal

General appearance - Remarks

Head/ear/nose/throat - Results

- ◯ Not examined
- ◯ Normal
- ◯ Abnormal

Head/ear/nose/throat - Remarks

Mouth/speech - Results

◯ Not examined ◯ Normal ◯ Abnormal

Mouth/speech - Remarks

Cardiovascular - Results

◯ Not examined ◯ Normal ◯ Abnormal

Cardiovascular - Remarks

Vascular - Results

◯ Not examined ◯ Normal ◯ Abnormal

Vascular - Remarks

Lungs and chest - Results

◯ Not examined ◯ Normal ◯ Abnormal

Lungs and chest - Remarks

Abdomen and viscera - Results

◯ Not examined ◯ Normal ◯ Abnormal

Abdomen and viscera - Remarks

Lymphatic - Results

◯ Not examined ◯ Normal ◯ Abnormal

Lymphatic - Remarks

Back/spine - Results

◯ Not examined ◯ Normal ◯ Abnormal

Back/spine - Remarks

Extremities/joints - Results

◯ Not examined ◯ Normal ◯ Abnormal

Extremities/joints - Remarks

Endocrine - Results

◯ Not examined ◯ Normal ◯ Abnormal

Endocrine - Remarks

Genito-urinary - Results

◯ Not examined ◯ Normal ◯ Abnormal

Genito-urinary - Remarks

Skin - Results

◯ Not examined ◯ Normal ◯ Abnormal

Skin - Remarks

Locomotor - Results

◯ Not examined ◯ Normal ◯ Abnormal

Locomotor - Remarks

Neurological system - Results

◯ Not examined ◯ Normal ◯ Abnormal

Neurological system - Remarks

Gait - Results

◯ Not examined ◯ Normal ◯ Abnormal

Gait - Remarks

Psychiatric - Results

◯ Not examined ◯ Normal ◯ Abnormal

Psychiatric - Remarks

Notes/recommendations

Healthcare practitioner's name: _____

Designation: _____

Signature

Date of examination: _____ dd / mm / yyyy