Medical Diagnosis Form

PATIENT INFORMATION

Name: _____ Date of birth: _____ dd / mm / yyyy

Contact Information: _____ Gender: _____

Emergency contact name: _____ Emergency contact number: _____

Physician name: _____ Physician ID: _____

MEDICAL HISTORY

Relevant past surgeries or hospitalizations:

Medications:

Allergies:

Relevant family medical history:

Other health complications or relevant preexisting conditions (e.g. long COVID-19):

PRESENTING COMPLAINT

Current symptoms (please include symptom duration, intensity, localization, factors that exacerbate or alleviate symptoms, and other relevant details):

REVIEW OF SYSTEMS

Please check any symptoms or issues the patient has described:

- [ ] Fever
- [ ] Shortness of breath
- [ ] Headache
- [ ] Nausea / Vomiting
- [ ] Fatigue
- [ ] Cough
- [ ] Chest pain
- [ ] Abdominal pain
- [ ] Diarrhea
- [ ] Other

PHYSICAL EXAMINATION

Physician observations:

DIAGNOSTIC TESTS

Test ordered:

- [ ] X-ray
- [ ] Blood tests
- [ ] Urine tests
- [ ] Other

Results:

ASSESSMENT AND RECOMMENDATION

Diagnosis:

Recommendations and referrals:

Physician name: _____ **Contact details:** _____

Signature:
Date: _____ dd / mm / yyyy