

Annual Check-up Checklist

Patient information	
Patient name:	Gender:
Date of birth:	Age:
Date of last annual check-up:	Date:
Medical history:	
History of medical procedures/hospitalizations (if applicable):	
Medications or supplements you currently take (if applicable):	
Vaccinations received (if applicable):	
Symptoms (if applicable):	
Lifestyle habits:	
Other relevant medical information:	

Health area		
Recommended screenings/ check-ups	Completed	Notes/remarks
Vitals		
Blood pressure		
Heart rate		
Temperature		
Weight		
Height		
Blood oxygen		
Respiration rate		
Others:		
Main check-up		
Complete blood count (CBC)		
Urinalysis		
Fecalysis		
Heart and lungs		
Abdominal		
Neurological		
Visual		
Ear, nose, and throat		
Skin		
Extremities		

Recommended screenings/ check-ups	Completed	Notes/remarks
Cancer screening		
Cholesterol		
Others:		
For men		
Testicular		
Prostate cancer screening		
Others:		
For women		
Mammogram		
Pap smear		
Pelvic examination		
Others:		
Additional notes		
Physician's name:		Signature: