

Consultation Form

Patient Information	
Name:	
Date of Birth:	
Gender:	
Contact Number:	
Address:	
Occupation:	
Emergency Contact:	

Medical History	
Chief Complaint:	
Present Illness:	
Past Illnesses:	
Allergies:	
Medications:	
Previous Surgeries:	

Family History	
Family Medical History:	
Genetic Conditions:	
Family Allergies:	

Lifestyle Factors	
Dietary Habits:	
Physical Activity:	
Sleep Patterns:	
Stress Levels:	
Tobacco/Alcohol/Drug Use:	

Assessment and Plan	
Physical Examination Findings:	
Diagnostic Tests Ordered:	

Provisional Diagnosis:	
Treatment Plan:	
Follow-up Recommendations:	

Informed Consent	
Explanation of Diagnosis and Treatment:	
Risks and Benefits:	
Patient Questions/Concerns Addressed:	

Doctor's Notes and Recommendations	
Additional Comments:	
Referrals to Specialists:	
Prescription Details:	

Doctor's Signature	
Name:	
Credentials:	
Date:	