Health Assessment Form

Patient information	
Name:	Date of birth:
Gender:	Contact information:
Address:	
Emergency contact person:	
Emergency contact person’s contact number:	
Date of assessment:	
Vitals	
Temperature:	Heart rate:
Blood pressure:	SPO2:
Respiratory rate:	
Medical history	
1. Primary care provider:	
2. Phone number:	
3. Date of last medical consultation:	
4. Current medications:	
Please list all medications, including prescription and over-the-counter.	
5. Allergies:	
Please list any known allergies to medications, food, or environmental factors.	

6. Past medical history:

Check all that apply.

☐ Diabetes	☐ Asthma
☐ Hypertension	☐ Heart disease
☐ Other (please specify):	

Lifestyle habits

1. Smoking status:

☐ Never smoked	☐ Former smoker
☐ Current smoker (packs/day):	

2. Alcohol consumption:

☐ None	☐ Occasional
☐ Regular (units/week):	

3. Exercise frequency:

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

3. Dietary habits:

Describe your typical daily diet.

Psychological information

1. Current stressors:

Please describe any current life stressors or challenges.

2. Mental health history:

Check all that apply.

☐ Depression	☐ PTSD
☐ Anxiety	☐ Other (please specify):

3. Current mental health support:

☐ None	☐ Counseling/therapy
☐ Support groups	☐ Other (please specify):
☐ Medication (please specify):	

4. Emotional well-being scale (1-10):

Rate your current emotional well-being.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

5. Suicidal thoughts or self-harm:

☐ Yes	☐ No

If yes, please elaborate:

Physical assessment

Category	Not examined	Normal	Abnormal	Remarks
General appearance	☐	☐	☐	
Head/ear/nose/throat	☐	☐	☐	
Mouth/speech	☐	☐	☐	
Cardiovascular	☐	☐	☐	
Vascular	☐	☐	☐	
Lungs and chest	☐	☐	☐	
Abdomen and viscera	☐	☐	☐	
Lymphatic	☐	☐	☐	

Category	Not examined	Normal	Abnormal	Remarks
Back/spine	☐	☐	☐	
Extremities/joints	☐	☐	☐	
Endocrine	☐	☐	☐	
Genito-urinary	☐	☐	☐	
Skin	☐	☐	☐	
Locomotor	☐	☐	☐	
Neurological system	☐	☐	☐	
Gait	☐	☐	☐	
Psychiatric	☐	☐	☐	
Notes/recommendations:				
Healthcare practitioner's name:				
Designation:				
Signature:				
Date of examination:				

Agency for Healthcare Research and Quality. (2012). *Appendix 10: Health assessment information for patients*. https://www.ahrq.gov/ncepcr/tools/assessments/health-ap10.html