Health Checklist

Date of assessment: July 7, 2025

Personal information	
Name of patient Jane Doe	**Date of birth:** July 6, 1997
Address: 47 W 13th St, New York, NY 10011, USA	
Contact information: janedoe@gmail.com	
Symptoms/concerns (if applicable):	
If the patient is a minor, please fill out the following information	
Parent or guardian's name: -	
Relationship to patient: -	
Contact information: -	
Medical history	
Personal medical history	
Vaccination received (if applicable):	
Up to date on all recommended vaccines.	
Medications or supplements currently taking (if applicable):	
None	
Past and present medical conditions, diseases, allergies, etc.:	
None.	
Family medical history	

Condition(s)	Relative
High Blood Pressure	Father
Diabetes	Grandparents (Mother's side)
Cancer	Aunt (Father's side)

Physical examination		
Vital signs		
Height: 5'5	Weight: 150lbs	Blood pressure: 100/70 mmHg
Pulse: 75 bpm	Vision: 20/20	Respiratory: 15 breaths/minute
Temperature: 37°C	Oxygen saturation: 98%	Other: N/A
Review of systems		
HEENT:	Cardiovascular:	Pulmonary:
No concerns.	No concerns.	No concerns.
Genito-urinary:	Gastrointestinal:	Musculoskeletal:
No concerns.	No concerns.	No concerns.
Skin:	Neurological:	Other:
No concerns.	No concerns.	N/A

Screening tests	
Test/examination	**Result**
N/A	N/A
N/A	N/A
N/A	N/A
N/A	N/A
N/A	N/A
N/A	N/A

Physical activity	
◉ Limited ○ Unlimited	
Describe your current physical activity:	**Recommendations from the physician:**
Mostly stretching.	Incorporate cardio and strength training.
Nutrition	
Describe your eating habits, diet, etc.:	**Recommendations from the physician:**
Generally eats healthy.	Drink more water.
Sleep	
Describe your sleep habits, quality, etc.:	**Recommendations from the physician:**
Average.	Find ways to improve sleep habits.
Lifestyle	
Describe your lifestyle (do you drink, smoke):	**Recommendations from the physician:**
No.	None.
Additional notes	
None.	
Physician's name: John Doe	
Signature: John Doe	**Date:** July 7, 2025