Health Checklist

Date of assessment:

Personal information	
Name of patient	**Date of birth:**
Address:	
Contact information:	
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):	
Medications or supplements currently taking (if applicable):	
Past and present medical conditions, diseases, allergies, etc.:	
Family medical history	

Condition(s)	**Relative**

Physical examination		
Vital signs		
Height:	Weight:	Blood pressure:
Pulse:	Vision:	Respiratory:
Temperature:	Oxygen saturation:	Other:
Review of systems		
HEENT:	Cardiovascular:	Pulmonary:
Genito-urinary:	Gastrointestinal:	Musculoskeletal:
Skin:	Neurological:	Other:

Screening tests	
Test/examination	**Result**

Physical activity	
◯ Limited ◯ Unlimited	
Describe your current physical activity:	**Recommendations from the physician:**
Nutrition	
Describe your eating habits, diet, etc.:	**Recommendations from the physician:**
Sleep	
Describe your sleep habits, quality, etc.:	**Recommendations from the physician:**
Lifestyle	
Describe your lifestyle (do you drink, smoke):	**Recommendations from the physician:**
Additional notes	
Physician’s name:	
Signature:	**Date:**