

# Medical Diagnosis Form

## Patient information

Name:

Date of birth:

Contact information:

Gender:

Emergency contact name:

Emergency contact number:

Physician name:

Physician ID:

## Medical history

Relevant past surgeries or hospitalizations:

Medications:

Allergies:

Relevant family medical history:

Other health complications or relevant preexisting conditions (e.g. *long COVID-19*):

## Presenting complaint

Current symptoms (*please include symptom duration, intensity, localization, factors that exacerbate or alleviate symptoms, and other relevant details*):

## Review of systems

Please check any symptoms or issues the patient has described:

Fever

Cough

Shortness of breath

Chest pain

Headache

Abdominal pain

Nausea/vomiting

Diarrhea

Fatigue

Other:

## Physical examination

Physician observations:

## Diagnostic tests

Tests ordered:

X-ray

Blood tests

Urine tests

Other:

Results:

## Assessment and recommendation

Diagnosis:

Recommendations and referrals:

Physician name:

Contact details:

Signature:



Date: