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: