

Patient Workup

Patient Information

Name:

Date of Birth:

Gender: Male Female Other:

Address:

Email:

Emergency Contact:

Insurance Information:

Medical History

Chief Complaint:

Present Illness History:

Past Medical History:

Surgical History:

Family History:

Social History:

Allergies:

Medication Review

Current Medications:

Dosage:

Frequency:

Duration:

Compliance:

Adverse Reactions:

Physical Examination**Vital Signs:**

Blood Pressure:

Heart Rate:

Respiratory Rate:

Temperature:

General Appearance:**Cardiovascular Examination:****Respiratory Examination:****Abdominal Examination:**

Neurological Examination:

Musculoskeletal Examination:

Skin Examination:

Diagnostic Studies

Laboratory Tests:

Complete Blood Count:

Comprehensive Metabolic Panel:

Lipid Profile:

Imaging Studies:

Chest X-ray:

ECG:

Other Diagnostic:

Assessment and Plan

Diagnosis:

Differential Diagnosis:

Therapy Goals:

Treatment Plan:

Pharmacological Interventions:

Non-Pharmacological Intervention:

Follow-up Recommendations:

Referrals to Specialists:

Notes

Signed by:

Date: