Wellness Check Report

Medical Institution Details

Name: ______________________________________

Address: ____________________________________

Phone Number: ______________________________

Website: ____________________________________

Patient Information

Full Name: __________________________________

Date of Birth: ______/______/_________

Gender: _____________________________________

Patient ID: __________________________________

Contact Number: ____________________________

Email Address: ______________________________

Physician/Healthcare Provider

Name: ______________________________________

Specialty: ___________________________________

Contact Number: ____________________________

Wellness Check Date

Date: ______/______/_________

Time: ____________________________

Vital Signs

Blood Pressure: _____________________________

Heart Rate: __________________________________

Respiratory Rate: ____________________________

Temperature: ________________________________

Oxygen Saturation: ___________________________

Health History Review

Medical History: _____________________________

Surgical History: _____________________________

Medications: ___________________________________

Allergies: _____________________________________

Family History: ________________________________

Social History (tobacco/alcohol use, exercise, diet): ________________________________

Physical Examination

General Appearance: ___________________________

Head and Neck: ________________________________

Cardiovascular: ________________________________

Respiratory: ___________________________________

Abdominal: ____________________________________

Musculoskeletal: _______________________________

Neurological: __________________________________

Dermatological: ________________________________

Screening Tests

BMI Calculation: _______________________________

Vision Test: ___________________________________

Hearing Test: ___________________________________

Blood Glucose: _________________________________

Cholesterol Profile: _____________________________

Other Relevant Screenings: ______________________

Immunizations and Preventive Measures

Influenza Vaccine:

- [ ] Yes
- [ ] No
- [ ] Up-to-date

Tetanus Booster:

- [ ] Yes
- [ ] No
- [ ] Up-to-date

Other Vaccinations: _____________________________

Lifestyle Assessment

Nutrition/Diet: ________________________________

Physical Activity: ______________________________

Stress Management: ___________________________

Sleep Quality: _________________________________

Patient Education

Diet and Nutrition: _____________________________

Exercise Recommendations: _____________________

Smoking Cessation: ____________________________

Alcohol Consumption: __________________________

Stress Reduction Techniques: ___________________

Plan/Recommendations

Follow-Up Appointments: _______________________

Referrals to Specialists: ________________________

Additional Tests or Screenings: __________________

Lifestyle Modifications: ________________________

Medication Adjustments: ________________________

Provider's Signature: _________________________ **Date:** ______/______/_________

Patient Acknowledgment

I have discussed the findings with the provider and understand the recommendations provided.

Patient's Signature: ____________________________

Date: ______/______/_________

Disclaimer: This wellness check template is for informational purposes only and should be adapted to reflect the protocols of the medical institution and the individual needs of the patient. Always consult with a qualified healthcare provider for personalized health assessments and recommendations.