Initial Medical Case Assessment

PATIENT INFORMATION

Full Name

Date of Birth

Gender

Contact Number

Address

REFERRING SOURCE

Referring Physician/Source

Date of Referral

PRESENTING COMPLAINT

Chief Complaint

HISTORY OF PRESENT ILLNESS

Describe symptoms, onset, duration, and any pertinent details

PAST MEDICAL HISTORY

Previous illnesses, surgeries, hospitalizations, allergies, medications

PHYSICAL EXAMINATION

Summary of relevant findings

INITIAL ASSESSMENT/IMPRESSION

Clinical impression or preliminary diagnosis

PLAN

Investigations, interventions, referrals, or follow-up

ASSESSED BY

Name

Date