Comprehensive Patient Assessment Checklist

Patient Information

Full Name		**Date of Birth**	
Gender		**Patient ID/Record #**	
Contact Number		**Address**	

Chief Complaint

History of Present Illness

Past Medical History

☐ **Diabetes**	☐ **Hypertension**	☐ **Asthma**	☐ **Heart Disease**
☐ **Cancer**	☐ **Stroke**	☐ **Allergies**	☐ **Other**

Details about medical history

Medication History

List all current medications

Family History

Social History

☐ **Tobacco**	☐ **Alcohol**	☐ **Substance Use**	☐ **None**

Occupation, living arrangement, lifestyle

Allergies

Review of Systems

☐ General (fever, weight loss)	☐ Skin	☐ HEENT	☐ Cardiac
☐ Respiratory	☐ GI	☐ GU	☐ Neuro
☐ Musculoskeletal	☐ Psych	☐ Other	

Comments / findings

Physical Examination

General appearance, vital signs, system exams

Assessment / Diagnosis

Plan / Recommendations

Provider Information

Name		**Date**	
Signature			