Initial Medical Screening Checklist

Patient Information

Full Name

Date of Birth

Gender

Contact Number

Address

Medical History

Any chronic illnesses?

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Asthma ☐ Other

Known allergies

Current medications

Vital Signs

Height (cm)

Weight (kg)

Blood Pressure

Pulse (bpm)

Temperature (Â°C)

Respiratory Rate

Symptoms Check

Are you experiencing any of the following?

☐ Fever ☐ Cough ☐ Shortness of Breath ☐ Fatigue ☐ Other

Other symptoms (please specify)

Clinical Notes

Observations/Notes