

Annual Check-up Checklist

Patient Name: _____

Date of Birth: _____

Gender: _____

Medical History:

History of Medical Procedures (if applicable):

Medication/Allergies (if applicable):

Symptoms (if applicable):

Lifestyle Habits:

Additional Notes:

Vitals

- Blood Pressure: _____
- Heart Rate: _____
- Temperature: _____
- Weight: _____
- Height: _____
- Blood Oxygen: _____
- Respiration Rate: _____

Checklist

- Blood Test (CBC)
- Physical Testing

- Heart and Lung Exam (Physical Testing)
- Abdominal Exam (Physical Testing)
- Neurological Exam (Physical Testing)
- Visual Exam (Physical Testing)
- Ear, Nose, and Throat Exam (Physical Testing)
- Skin Exam (Physical Testing)
- Extremities Exam (Physical Testing)
- Urinalysis
- Fecalalysis
- Cancer Screening

For Men

- Testicular Exam
- Hernia Exam
- Prostate Exam

For Women

- Pap Smear
- Pelvic Exam
- Breast Examination

Other Tests Requested: _____

Referring Physician's Name: _____

Date: _____