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
- [ ] Fecalysis
- [ ] 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: _____