

Consultation Form

| Patient Information | |
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| Name: | |
| Date of Birth: | |
| Gender: | |
| Contact Number: | |
| Address: | |
| Occupation: | |
| Emergency Contact: | |

| Medical History | |
|---------------------|--|
| Chief Complaint: | |
| Present Illness: | |
| Past Illnesses: | |
| Allergies: | |
| Medications: | |
| Previous Surgeries: | |

| Family History | |
|--------------------------------|--|
| Family Medical History: | |
| Genetic Conditions: | |
| Family Allergies: | |

| Lifestyle Factors | |
|----------------------------------|--|
| Dietary Habits: | |
| Physical Activity: | |
| Sleep Patterns: | |
| Stress Levels: | |
| Tobacco/Alcohol/Drug Use: | |

| Assessment and Plan | |
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| Physical Examination Findings: | |
| Diagnostic Tests Ordered: | |

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| Provisional Diagnosis: | |
| Treatment Plan: | |
| Follow-up Recommendations: | |

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| Informed Consent | |
| Explanation of Diagnosis and Treatment: | |
| Risks and Benefits: | |
| Patient Questions/Concerns Addressed: | |

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| Doctor's Notes and Recommendations | |
| Additional Comments: | |
| Referrals to Specialists: | |
| Prescription Details: | |

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|---------------------------|--|
| Doctor's Signature | |
| Name: | |
| Credentials: | |
| Date: | |