Diagnosis Form

Patient information	
Name:	**Date of birth:**
Gender:	**Patient ID:**
Contact information:	
Emergency contact details:	
Date of visit:	
I. Clinical history	
Presenting/chief complaint:	**History of present illness:**
Past medical history:	**Family history:**
Social history:	**Medications and allergies:**

II. Physical examination	
General appearance:	
Vital signs:	
Temperature:	Blood pressure:
Heart rate:	Respiratory rate:
Physical findings:	
III. Diagnostic testing	
Test(s) ordered	**Preliminary results**
IV. Diagnosis	
Primary diagnosis:	**Secondary diagnosis (if applicable):**

V. Referrals and consultations	
Clinician information	
Name:	License ID/number:
Date:	Signature: