

Health Note

Patient's Full Name:

Date of Birth:

Address:

Phone Number:

Emergency Contact Information:

Date of Visit:

I. Chief Complaint

(Describe the primary reason for the patient's visit in the patient's own words.)

II. History of Present Illness

(Provide a detailed description of the patient's current symptoms, including onset, duration, frequency, severity, and any factors that alleviate or exacerbate the symptoms.)

III. Past Medical History

(List any previous medical conditions, hospitalizations, surgeries, or significant illnesses, including dates.)

IV. Medications

(List all current prescription and over-the-counter medications, including doses and frequencies.)

V. Allergies

(List any known allergies to medications, foods, or environmental factors.)

VI. Social History

(Include relevant information about the patient's lifestyle, such as occupation, exercise habits, smoking status, alcohol consumption, and other factors that may impact their health.)

VII. Family Medical History

(Document any significant medical conditions in the patient's immediate family, including parents, siblings, and children.)

VIII. Review of Systems

(Record any additional symptoms or issues in various body systems, organized by system, e.g., cardiovascular, respiratory, gastrointestinal, etc.)

IX. Physical Examination

(Document the findings of the physical examination, including vital signs (blood pressure, heart rate, respiratory rate, and temperature), and observations for each relevant body system.)

Assessment and Plan

(Provide a summary of the patient's health status, including any diagnoses, and outline the recommended treatment plan, including any medications, referrals, or follow-up appointments.)