Patient Self-Evaluation Form

Please take a few moments to complete this self-evaluation form. Your responses will help us better understand your health status and provide you with the best possible care.

Personal Information:
Full Name:
Date of Birth:
Gender:
Contact Number:
Email Address:
Health History:
1. Have there been any changes in your medical history since your last visit? If yes, please specify:
2. List any medications you are currently taking (prescription or over-the-counter):
3. Do you have any known allergies? If yes, please list them:
Current Symptoms:
Please rate the severity of the following symptoms on a scale from 1 to 10, with 1 being mild and 10 being severe.
1. Fatigue:
2. Pain (specify location):
3. Shortness of breath:
4. Fever or chills:
5. Cough:
6. Other symptoms (please specify):

Lifestyle and Habits:
How would you describe your current diet? (e.g., balanced, vegetarian, vegan, etc.)
Do you engage in regular physical activity? If yes, please describe your routine:
Do you smoke? ☐ Yes ☐ No
If yes, how many cigarettes per day?
Do you consume alcohol? ☐ Yes ☐ No
If yes, how often and in what quantity?
Mental Health:
1. How would you rate your stress level on a scale from 1 to 10, with 1 being low and 10 being high?
2. Have you experienced any significant changes in your mood or mental well-being recently? If yes, please elaborate:
Additional Comments or Concerns:
Please use this space to provide any additional information or express any concerns you may have:

Signature: I confirm that the information provided in this self-evaluation form is accurate to the best of my knowledge.

Signature: ____________________________________ Date: __________________________