Medway Hospitals

The way to better health

OUT PATIENT ASSESSMENT FORM

Patient	Age	Sex: M /	
Doctor	UHID	Date	Time

ALLERGIES if any(yes/No), If Yes, Specify:

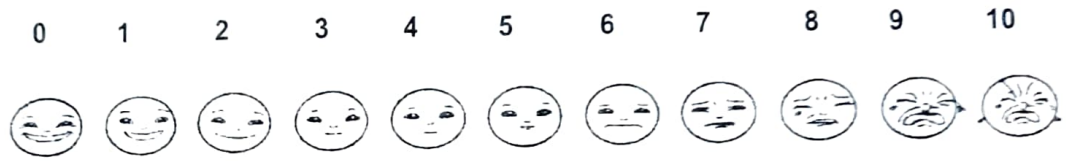
Vital signs:

Temperature :
Pulse Rate :
Respiratory Rate :

BP :
SpO2 :

Height :
weight :

PAIN ASSESSMENT SCALE



Pain: Score (0 – 10)_____ Location: Character:

Chief complaints with duration:

Past History: ↕ Notes

Medical history	Yes	No	Duration	Medication
Diabetes mellitus				
Hypertension				
CAD				
Bronchial asthma				
Others				

Surgical History:

Psychosocial History: Alcohol ☐ Smoking ☐ Tobacco ☐ Others.....

Nutritional:

Screening :

Physical Examination:

General Examination:

Pallor ☐ Cyanosis ☐ Icterus ☐ Clubbing ☐ Pedal Oedema ☐ Anasarca ☐

Functional Assessment: Ability to perform routine activities : **Yes/No**

Abdominal Examination :

Nervous System Examination

:

Per Rectal Examination

:

Per Vaginal Examination :

Results of Investigations reports: Enclosed (YES/NO):

Provisional Diagnosis:

Plan of Care :

Investigations Ordered :

Diet :

Doctor Signature :

Doctor Name :

Time :