



Patient record: General Practice

Blank form to fill in by hand.

Clinic

Doctor

Date

____ / ____ / ____
dd/mm/yyyy

Essentials

First name

Last name

Date of birth

____ / ____ / ____
dd/mm/yyyy

Place of birth

Nationality

Profession

Phone number

Email

Address

Gender

☐ Female ☐ Male ☐ Non binary ☐ Prefer not to say

1. Reason for Visit

Presenting complaint

History of present illness

2. Vital Signs

Measurements

Date	Blood pressure	Heart rate	Temperature	SpO ₂ (%)	Weight

3. Medical History

Hypertension? ☐ Yes ☐ No

If yes, give details: _____

Diabetes? ☐ Yes ☐ No

If yes, give details: _____

Cardiac disease? ☐ Yes ☐ No

If yes, give details: _____

Respiratory disease? ☐ Yes ☐ No

If yes, give details: _____

Thyroid disease? ☐ Yes ☐ No

If yes, give details: _____

Allergies? ☐ Yes ☐ No

If yes, give details: _____

Pregnant or breastfeeding? ☐ Yes ☐ No

If yes, give details: _____

Smoking status

☐ Never ☐ Former ☐ Current

Family history

Previous surgery and admissions

4. Medications

Current medication

Medication	Dose	Frequency	Started

5. Examination and Plan

Physical examination

Diagnosis

Treatment plan

Investigations and referrals

6. Consent

Informed consent

- 1. I have been informed in an understandable way about my diagnosis, the purpose of the proposed treatment, the procedures that may be performed, reasonable alternatives, expected benefits, limitations and possible risks.
- 2. I have been informed that the outcome of treatment cannot be guaranteed absolutely and that additional procedures, check-ups or treatment may be needed depending on the clinical situation.
- 3. I have had the opportunity to ask questions, and I declare that the answers I received were sufficient for my decision.
- 4. I authorize the physician and clinical staff to perform the agreed treatment and clinically necessary supporting procedures within the treatment plan discussed with me.
- 5. I have been informed that I have the right to refuse the treatment or to withdraw this consent at any time. Withdrawal does not affect procedures performed before it.

Patient or Legal Representative Signature

Doctor Signature

Date:

Date:

Signature

Date

____ / ____ / ____
dd/mm/yyyy