

Medical Examination Form California

Patient Profile

- Patient Name: _____
- DOB: _____
- Insurance ID: _____
- Emergency Contact: _____

Comprehensive Health Review

- Past Surgical History: _____
- Family Medical History: _____
- Lifestyle Information: _____

Physical Assessment

- Respiratory Rate: _____
- Heart Rate: _____
- Temperature: _____

Diagnostic Summary

- Lab Tests Ordered: _____
- Imaging Required: _____
- Follow-up Needed: _____

Consent and Verification

- Patient Consent: (Checkbox) Agreed Not Agreed

- **Doctor's Signature:** _____
- **Date:** _____