Medical Examination Form PDF

Patient Identification

- **Name: ________________________________**
- **Date of Birth: __________________________**
- **Gender: _________________________________**
- **Contact Number: ________________________**

Medical History

- **Known Conditions: ______________________**
- **Current Medications: ___________________**
- **Allergies: ______________________________**

Examination Details

- **Height: ______________________________**
- **Weight: ______________________________**
- **Blood Pressure: _________________________**
- **Vision Test: ___________________________**

Examination Results

- **Findings: ______________________________**
- **Recommendations: _______________________**
- **Physician's Comments: __________________**

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Physician Signature

- **Signature: ______________________________**
- **Date: ___________________________________**

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