Medical Examination Report Form

**Examinee Information**

* **Name of Examinee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Examination Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physical Examination**

* **Height: \_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_ BMI: \_\_\_\_\_\_\_\_**
* **Vision: Left Eye: \_\_\_\_\_\_\_\_ Right Eye: \_\_\_\_\_\_\_\_**

**Medical Test Results Table**

| **Test Type** | **Date** | **Result** | **Notes** |
| --- | --- | --- | --- |
| **Blood Pressure** |  |  |  |
| **Glucose Level** |  |  |  |
| **Cholesterol** |  |  |  |
| **ECG** |  |  |  |
| **X-ray** |  |  |  |
| **MRI** |  |  |  |
| **Ultrasound** |  |  |  |
| **Other Tests** |  |  |  |

**Physician's Notes**

* **Observations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Recommendations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Consent and Declaration**

* **I consent to the use of my medical data for the purpose of this examination: ☐ Yes ☐ No**

**Physician's Signature**

* **Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**