

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:** _____