Physical Certificate Form Online

**Patient Identification  
  
Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date of Birth (MM/DD/YYYY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Current Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Health History  
  
Chronic Illnesses: □ Yes □ No □ Not Disclosed  
Current Medications: □ Yes □ No □ Not Disclosed  
If yes to either, please elaborate in the space below:**

**Physical Check-up Details  
  
Height: \_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_ Body Mass Index (BMI): \_\_\_\_\_\_\_\_\_\_\_\_  
Blood Pressure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Overall Fitness Level:  
□ Excellent □ Good □ Average □ Below Average**

**Doctor's Certification  
  
I hereby certify that the information herein is complete and accurate to the best of my knowledge and that the patient has been examined accordingly.  
  
Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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