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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**