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: __________________________________

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Date: ___________________

Signature: _____________________________________

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