**Printable Physical Certificate Form**

**Patient Information

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical History

Do you have any chronic illnesses? □ Yes □ No
If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Are you currently taking any medication? □ Yes □ No
If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physical Examination

Height: \_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_ BMI: \_\_\_\_\_\_\_\_\_\_
Blood Pressure: \_\_\_\_\_\_\_\_\_\_ Pulse Rate: \_\_\_\_\_\_\_\_\_\_
Vision: Left Eye \_\_\_\_\_\_\_\_\_\_ Right Eye \_\_\_\_\_\_\_\_\_\_**

**Physician's Assessment

General Health Status:
□ Excellent □ Good □ Fair □ Poor
Specific Conditions Diagnosed During Examination:**

**Certification**I certify that the above information is accurate and that the individual named herein has been examined by me. **Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ License Number: \_\_\_\_\_\_\_\_\_\_\_\_
Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**