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: _____