# Health Physical Form

**Personal Information**

- Name: _____
- Insurance Number: _____
- Address: _____
- Phone Number: _____

**General Health Assessment**

- Chronic illnesses (e.g., heart disease, diabetes): _____
- Allergies: _____
- Medications currently taking: _____

**Vital Signs & Examination**

| Parameter | Value | Normal Range |
|---|---|---|
| Blood Pressure | _____ | 120/80 mmHg |
| Heart Rate | _____ | 60-100 bpm |
| Blood Sugar | _____ | < 140 mg/dL |
| Cholesterol Level | _____ | < 200 mg/dL |

**Patient Consent for Health Examination**

I authorize the healthcare provider to perform the necessary health checks.

Signature: _____ Date: _____