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