Medical Physical Exam Form

Patient Information:

Full Name: _____

Date of Birth: _____

Address: _____

Emergency Contact: _____

Medical History Checklist:

☐ **Allergies**

☐ **Asthma**

☐ **Diabetes**

☐ **High Blood Pressure**

☐ **Other (Specify):** _____

Exam Findings:

Height: _____

Weight: _____

Temperature: _____

Pulse Rate: _____

Physician's Comments:

Observations: _____

Recommendations: _____

Authorization:

Patient/Guardian Signature: _____

Date: _____

Physician's Name: _____

Physician's Signature: _____