Physical Exam Form for Work

Employee Information:

Full Name: _____

Job Title: _____

Employer Name: _____

Contact Information: _____

Medical History:

☐ No Known Medical Conditions

☐ Allergies (Specify): _____

☐ Ongoing Medication (Specify): _____

Physical Exam Findings:

Height: _____

Weight: _____

Blood Pressure: _____

Vision: ☐ Normal ☐ Corrective Lenses Required

Workplace Fitness Table:

Test/Observation	Results	Comments	Follow-up Required
General Health			
Physical Agility			
Respiratory Check			
Cardiovascular Health			

Certification of Fitness:

Examining Physician's Name: _____

Physician's Signature: _____

Date: _____