**Annual Physical Assessment Form**

**Personal Information:
Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Annual Assessment Table:**

| **Test/Screening** | **Completed** | **Not Required** | **Notes** |
| --- | --- | --- | --- |
| **Blood Test** | **[ ]** | **[ ]** |  |
| **Vision Screening** | **[ ]** | **[ ]** |  |
| **Hearing Test** | **[ ]** | **[ ]** |  |
| **Cholesterol Check** | **[ ]** | **[ ]** |  |
| **Diabetes Screening** | **[ ]** | **[ ]** |  |
| **Cancer Screening** | **[ ]** | **[ ]** |  |
| **Bone Density** | **[ ]** | **[ ]** |  |
| **Mental Health Check** | **[ ]** | **[ ]** |  |

**Doctor's Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**