PHYSICAL EXAMINATION FORM

Date:

Name:

Identification No.

Date of Birth:

Height: Weight:

HEALTH HISTORY

Yes	No	
☐	☐	Diabetes
☐	☐	Muscular Disease
☐	☐	Mental Disorder
☐	☐	Arthritis
☐	☐	Serious Injuries
☐	☐	Suffering From Any Other Diseases
☐	☐	Lung Disorders (asthma, tuberculosis, shortness of breath)
☐	☐	Cardiovascular Disease (rheumatic fever, scarlet fever, diphtheria)
☐	☐	Nervous System Disorders (dizziness, epilepsy, syphilis)
☐	☐	Currently Under a Physician's Care
☐	☐	Permanent Impairment From Illness, Disease, or Injury
☐	☐	Suffering From Any Other Diseases

GENERAL

General Appearance and Development: ☐ Good ☐ Fair ☐ Poor

Hearing: Right Ear: Left Ear: Disease or Injury:

Thorax: Heart:

Blood Pressure: Systolic: Diastolic:

Pulse: Before Exercise: Immediately After Exercise:

Abdomen: Scars: Abnormal Masses: Tenderness:

Reflexes: Accommodation: Right: Left: