# Printable Physical Assessment Form

(This form should be filled completely by a nurse, doctor, physician or a medical practitioner or their assistants.)

Date: ______________________

**Patient Details**

Name: ______________________________________ Age: _________ Date of Birth: ______________

Address: ________________________________________ State: ______________ Zip: ______________

Phone: _______________________________________ Email: ____________________________________

**Health condition**

Height: _____________ Weight: ______________

Vision: Left: ______/______ uncorrected /corrected ________________________________________

Right: ______/______ uncorrected /corrected ________________________________________

Glasses ______________________ Contacts ______________________

Blood pressure ______/______ Pulse ________________________ Hearing ____________

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