

Annual Physical Exam Checklist By Age

Patient Name: _____

Date of Birth: _____

Gender: _____

Medical History:

History of Medical Procedures (if applicable):

Medication/Allergies (if applicable):

Symptoms (if applicable):

Lifestyle Habits:

Additional Notes:

Vitals

- Blood Pressure: _____
- Heart Rate: _____
- Temperature: _____
- Weight: _____
- Height: _____
- Blood Oxygen: _____
- Respiration Rate: _____

Checklist by Age

Test	18 - 39	40 - 64	65+
Blood Sugar Testing			
Cholesterol Blood Testing			
Heart Disease Prevention			
Infectious Disease Screening			
Physical Exam			
Eye Exam			
Testicular Exam (Males)			
Prostate Cancer Screening (Male)			
Pap Smear (Female)			
Breast Exam (Females)			
Mammogram (Females)			
Lung Cancer Exam			
Osteoporosis Screening			
Colorectal Screening			
Abdominal Aortic Aneurysm Screening			
Immunizations			
Hearing Test (Auditory)			
Hepatitis C Blood Test			
STD			
Others: _____			

Referring Physician's Name: _____

Date: _____