Annual Physical Exam Checklist by Age

Patient information	
Patient name:	Date of birth:
Gender: ◯ Male ◯ Female ◯ Other:	
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:** _____