Physical Form

Name: ______________________________

Date: ______________ Age: ______________ Gender: ______________

Part 1 Instructions:

Please read the following questions and answer them with 'Yes' or 'No.' Your answers will help the healthcare professional assess your overall health.

Yes	No	
☐	☐	1. Do you have any known allergies to medications, food, or environmental factors?
☐	☐	2. Are you taking prescription or over-the-counter medications, vitamins, or supplements?
☐	☐	3. Do you have a history of chronic medical conditions like diabetes, high blood pressure, or heart disease?
☐	☐	4. Have you ever been hospitalized or undergone surgery for any reason?
☐	☐	5. Do you have a family history of significant medical conditions like heart disease, stroke, or cancer?
☐	☐	6. Do you exercise regularly (at least 30 minutes thrice a week)?
☐	☐	7. Do you smoke tobacco, consume alcohol, or use recreational drugs?
☐	☐	8. Have you experienced significant weight gain or loss within the last six months?
☐	☐	9. Do you regularly experience difficulty sleeping or suffer from insomnia?
☐	☐	10. Have you noticed any recent changes in your mood, energy levels, or overall well-being?

Part 2 Instructions:

Complete the physical exam form, and enter the patient's personal information and medical history in the designated sections. Next, record the patient's vital signs and proceed with a head-to-toe examination, documenting any findings in the appropriate sections for each body system. If additional tests or notes are necessary, include them in the designated rows. Once the examination is complete, the examining physician should sign and date the form to validate the findings.

Section	Description	Findings
Patient Information	Full Name:	
	Date of Birth:	
	Gender:	
	Address:	
	Phone Number:	
	Emergency Contact:	
Medical History	Allergies:	
	Past Surgeries:	
	Current Medication:	
	Family History of Illnesses:	
	Tobacco/Alcohol/Drug use:	
Vital Signs	Blood Pressure:	
	Heart Rate:	
	Respiratory Rate:	
	Temperature:	
	Height:	
	Weight:	

General Appearance	Overall appearance, hygiene, and demeanor:	
Head and Neck	Head: symmetry, scalp, and hair	
	Eyes: visual acuity, pupils, and extraocular movements	
	Ears: hearing, tympanic membranes, and ear canals	
	Nose: patency, septum, and mucosa	
	Mouth and Throat: teeth, gums, tongue, and tonsils	
	Neck: lymph nodes, thyroid, trachea, and carotid arteries	
Cardiovascular	Heart: rate, rhythm, and murmurs	
Respiratory	Lungs: breath sounds, wheezing, and crackles	
Abdomen	Inspection, palpation, and auscultation	
Genitourinary	External genitalia and inguinal nodes	
Musculoskeletal	Range of motion, strength, and deformities	
Neurological	Cranial nerves, motor, sensory, reflexes, and coordination	
Skin	Color, texture, turgor, and lesions	
Additional Test/s	Lab tests, imaging, or other diagnostic tests	
Physicians Signature		
Guardian/Parent Signature (If a minor or student)		