Physical Examination

A. Physical Examination Statement Date: _____
B. Name: _____ DOB:___/___/____
C. **Please complete the following:**

1. BP: _____ Height: _____ weight: _____
2. Allergies: _____
3. Past Injuries: _____
4. Past illnesses: _____
5. Medications: _____
6. Hearing: _____
7. Vision: _____
8. Heart: _____
9. Back: _____
10. Lung: _____
11. Hernia: _____
12. PPD: _____ Date: _____ Result: _____
13. Chest X-Ray: _____

To be completed by Physician:

I certify _____ is free of communicable disease by my examination and is able to perform the duties of _____

Without restrictions and accommodations.

Comments:

_____
_____
_____

Physician/ NP's Signature: _____

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