Physical Form

Name: ______________________________________ **Gender:** ______________________________

Date of birth: _______________________________ **Date:** _________________________________

Part 1: Health questionnaire (to be completed by the patient)

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

Questions	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 weekly)?		
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: Physical examination form (to be completed by the healthcare professional)

Instructions: Complete the physical exam form by entering the patient's personal information and medical history in the designated sections. Record the patient's vital signs and perform 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.

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

Physician's signature	**Date**
Guardian/parent signature (if a minor or student)	**Date**