

MEDICAL EXAMINATION FORM

Last Name _____, First Name _____ Middle Initial _____ Sex _____ Age _____ Civil Status _____

Mailing Address _____ Date of Birth _____ Place of Birth _____

Next of Kin (Relationship) _____ Address _____ Tel. No. _____

Date of Examination _____ Purpose of Examination _____

Clinical Evaluation

Physician's Findings _____ Describe abnormality in detail
Enter pertinent number for every comment

Normal: _____

Abnormal: _____

1. Eyes _____
2. Ears _____
3. Nose _____
4. Throat _____
5. Teeth _____
6. Lungs _____
7. Heart _____
8. Abdomen _____
9. Genitalia _____
10. Posture _____
11. Extremities _____
12. Skin _____
13. Identifying Marks _____

Measurements and other Findings

Weight _____ Height: _____ Color of Hair: _____ Color of Eyes: _____

Blood Pressure (Sitting) Systolic: _____ Diastolic: _____

Vision: Distant vision : Right _____ Left _____

Near vision : Right _____ Left _____

Hearing: (ears) : Right _____ Left _____

Past Medical History : Serious diseases, operations, injury, etc.

Laboratory Findings

Blood Examination : Type _____ etc. _____

Urinalysis : Albumin _____ Sugar _____ Microscopic _____

Chest X-ray : Date Taken _____ Results _____

Electrocardiogram : Date taken _____ Results _____

Other Tests : _____

REMARKS & RECOMMENDATION

Signature of Examinee _____

Medical Examiner _____

License No. _____