HEALTH SERVICES PHYSICAL EXAMINATION

This form must be completed by your Physician/Healthcare provider.

PATIENT INFORMATION (please print in ink or type)

Name: _____ Birthday: _____
Last First Middle Month/Day/Year

PHYSICIAN/PROVIDER SUMMARY

HT _____ WT _____ BP _____

	Abnormal/Normal	Comments
HEENT	☐ / ☐	_____
SKIN	☐ / ☐	_____
HEART	☐ / ☐	_____
LUNGS	☐ / ☐	_____
ABDOMEN	☐ / ☐	_____
MUSCULOSKELETAL	☐ / ☐	_____
NEUROLOGICAL	☐ / ☐	_____

List ALL past or present medical conditions that we need to be aware of: _____

_____

_____

Are there any conditions (i.e. recent surgery or illness, chronic health problem) that would limit the patient from participating in physical activities? **CIRCLE ONE: YES NO**
If you answered YES, please explain: _____

_____

_____

Does the patient take any medication? If so, please list: _____

_____

_____

If the patient is under a current treatment program that you would like to continue, please enclose/attach pertinent medical history and recommendations.

Signature of Healthcare Provider: _____ Date: _____

Healthcare Provider Name or Office: _____

Address: _____

Phone: _____ Fax: _____