

PHYSICAL EXAMINATION FORM

1	Applicant Information		
First Name _____		Last Name _____	
Date of Birth _____		*Social Security # _____	
Home Address _____		Phone Number _____	
City _____		State _____	Zip _____
License Type: _____		License Number (if licensed) _____	

2	Health History	TO BE FILLED IN BY EXAMINING PHYSICIAN (Please print)
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	Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Head or spinal injuries	
<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Seizures, fits, convulsions or fainting	
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Extensive confinement by illness or injury	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Any other nervous disorder	
<input type="checkbox"/>	<input type="checkbox"/>	Nervous Stomach	<input type="checkbox"/>	<input type="checkbox"/>	Ethanol use	<input type="checkbox"/>	<input type="checkbox"/>	Suffering from any other disorder	
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Rx drug use	<input type="checkbox"/>	<input type="checkbox"/>	Permanent defect from illness, disease or injury	
<input type="checkbox"/>	<input type="checkbox"/>	Over the counter drug use							

IF ANSWER TO ANY OF THE ABOVE IS YES, EXPLAIN:

General Fitness and Health: Good Fair Poor

Vision: For Distance: Right/20 Both/20 Without Corrective Lenses
 With Corrective Lenses

Evidence of disease or injury Right _____ Left _____

Color Test _____

Horizontal Field of Vision: Right _____ Left _____

Hearing: Right _____ Left _____

Evidence of disease or injury Right _____ Left _____

Audiometric Test: Decibel loss at 500HZ 1,000 HZ 2,000 HZ 3,000 HZ 4,000 HZ

Throat: _____

Thorax: Heart: _____

If organic disease is present, is it fully compensated? _____

Blood Pressure: Systolic _____ Diastolic _____

Pulse: Before Exercise _____ Immediately after _____

Lungs: _____

Abdomen: Scars _____ Abdominal Masses _____ Tenderness _____

Generic Physical Examination Form

J Spring



Generic Physical Examination Form:

Generic Physical Examination Form Book Review: Unveiling the Power of Words

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