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## **Medical Certificate Forms Online**

**Patient Information:**

* Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Examination Date:**

* Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Examination Details:**

* Height: \_\_\_\_\_\_\_\_\_\_\_
* Weight: \_\_\_\_\_\_\_\_\_\_\_
* Blood Pressure: \_\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_
* Pulse Rate: \_\_\_\_\_\_\_\_\_\_\_ beats per minute
* Temperature: \_\_\_\_\_\_\_\_\_\_\_ °F/°C

**Medical History Review:**

* Any known allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Current medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Past surgeries or hospitalizations: \_\_\_\_\_\_\_\_\_\_\_\_
* Chronic illnesses (e.g., diabetes, hypertension): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physical Examination Summary:**

* General Appearance: [Healthy/Frail/etc.]
* Eyes: [Normal/Abnormal - specify if necessary]
* Ears, Nose, Throat: [Normal/Abnormal - specify if necessary]
* Cardiovascular System: [Normal/Abnormal - specify if necessary]
* Respiratory System: [Normal/Abnormal - specify if necessary]
* Gastrointestinal System: [Normal/Abnormal - specify if necessary]
* Musculoskeletal System: [Normal/Abnormal - specify if necessary]
* Neurological System: [Normal/Abnormal - specify if necessary]
* Dermatological Condition: [Normal/Abnormal - specify if necessary]

**Physician's Findings and Recommendations:**

* [Details of findings, diagnosis, and any recommended treatments or follow-up actions.]

**Certification:**

* I certify that I have examined the above-named patient and, to the best of my knowledge, he/she is in [state of health, e.g., good/poor] health.

**Physician's Signature and Stamp:**

* Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Qualification: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Registration Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Stamp: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_