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: _____