

Physician's Report of Physical Examination

PATIENT INFORMATION:

Patient's Name: Last _____ First _____ MI _____

Date of Birth: ____/____/____ Current Age: _____ Date of Examination: ____/____/____

Significant Medical History (Please include surgeries, hospitalizations, chronic conditions, allergies):

Dietary Restrictions:

Current Medications:

Conditions Currently Under Treatment:

PHYSICAL EXAMINATION---Please describe any abnormalities:

Height: _____ Weight: _____ BP: _____ Pulse: _____ Respirations: _____

Corrected Vision: Right _____ Left _____ Date of Last Tetanus: (DPT, DT, TT) **MUST be listed** _____

General Appearance/Nutrition: _____

ENT: _____

Pulmonary: _____

Cardiac: _____

Neurological: _____

Musculoskeletal: _____

GI/Abdominal: _____

Mental/Emotional: _____

Any physical activity restrictions? Describe: _____

This person is in satisfactory condition and may engage in all usual activities except as noted above. I believe this person is able to engage in wilderness hiking/camping/caving/biking/kayaking/rafting/rock climbing/horseback riding/water-skiing/water tubing/wakeboarding/knee boarding and other activities involving strenuous forms of physical activity.

Physician's Signature: _____ Date: _____

Physician's Printed Name and Degree : _____

Physician's Address: _____

Physician's Phone Number: _____