



Annual Physical Form

Name:	DOB:	HT:	WT:	Date:
BP:	HR:	RR:	PO:	Temp:

Allergies:

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Medications:

Current Problem List:

Exercise/Wellness/Nutrition:

Strength Training:
Cardio:
Diet:



Medical and Surgical History:

Risk Factors/Social History/How Often:

Alcohol:	Caffeine:
Smoking/Any Form of Nicotine:	
Drugs:	

Other recommendations/Referrals:

Physician Name:	Date:
Physician Signature:	