Family Practice Routine Physical Evaluation Form

Patient Information

Name

Date of Birth

Today's Date

Gender Select

Phone

Email

Address

Vitals

Height in/cm

Weight lb/kg

Blood Pressure mmHg

Heart Rate bpm

Temperature Â°F/Â°C

Medical History

Previous illnesses, surgeries, chronic conditions

Current Medications

Allergies

Family History

Describe any relevant family medical history

Review of Systems

List any symptoms or concerns (ex: vision, chest pain, joint pain, etc.)

Physical Examination Notes

Summarize findings from the physical exam

Assessment & Plan

Assessment

Plan (tests, referrals, follow-up, etc.)

Physician Name

Signature

Date