



Surname _____		Given names _____	
Born _____		Profession/Title _____	
PHYSICAL EXAMINATION			
1. General condition		Height _____	cm
Appearance	<input type="checkbox"/> healthy <input type="checkbox"/> pale <input type="checkbox"/> sickly	Weight _____	kg
Nutrition	<input type="checkbox"/> fat <input type="checkbox"/> average <input type="checkbox"/> thin	Chest measure _____	cm
2. Physique			
<input type="checkbox"/> strong <input type="checkbox"/> average <input type="checkbox"/> weak			
Musculature			
<input type="checkbox"/> strong <input type="checkbox"/> average <input type="checkbox"/> weak			
Spine	<input type="checkbox"/> normal	Chest wide	<input type="checkbox"/> average <input type="checkbox"/> shallow <input type="checkbox"/> narrow
Extremities	<input type="checkbox"/> normal	Feet	<input type="checkbox"/> normal <input type="checkbox"/> low <input type="checkbox"/> flat
Malformations or troublesome scars		<input type="checkbox"/> no	<input type="checkbox"/>
3. Lungs			
4. Heart		Blood Pressure	
		Systolic / Diastolic	
5. Teeth			
<input type="checkbox"/> good <input type="checkbox"/> satisfactory		<input type="checkbox"/> poor	
6. Urine			
Albumen		Sugar	
7. Vision			
<input type="checkbox"/> without glasses			
<input type="checkbox"/> with glasses		<input type="checkbox"/> normal <input type="checkbox"/> Eye diseases	
8. Hearing			
<input type="checkbox"/> normal		<input type="checkbox"/> Ear diseases	
9. Signs of tuberculosis or other contagious diseases			
		<input type="checkbox"/> no <input type="checkbox"/>	
10. Remarks _____			

On the basis of this examination I consider the applicant to be ablebodied and not a carrier of any contagious disease.			
Place _____		Date _____	
Signature of applicant _____		Signature of examining physician _____	