VISIT FORM

Patient Name: _____ **DOB**: ___/____/_____**AGE**: _____

Today's Date: ___/___/_____ **Appointment Time**: _____ **Time In**: _____

Reason for visit: _____

_____

Are you allergic to any medications? _____

What Medications Do You Take?

_____ _____ _____

_____ _____ _____

Sign:

Patient: _____ **Date**:_____

Authorized Person: _____ **Relationship to Patient**: _____

TO BE FILLED BY DOCTOR

Height	Weight	BP	Pulse	Temp	SAT	Pain

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