INTERNAL MEDICINE/PEDIATRICS

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VISIT FORM

Patient Name : _____ Age: _____

Today's Date : _____

Reason for visit: _____

_____

Drug Allergies : _____

List of Medicines : (circle those which need refills)

_____ _____

_____ _____

_____ _____

_____ _____

Sign:

Patient : _____ Date : _____

Authorized Person : _____ Relationship to patient : _____

TO BE FILLED BY STAFF

Height	Weight	BP	Temp.	Pulse	SAT	Pain