Patient Medical Treatment Record

Date:______________________________

Name: ____ **Age/DOB**:____________/____________

Gender:☐M ☐F **Contact Information**:____

Vital Signs: **Temp**_________ **HR**__________ **RR**__________ **BP**__________ **Gluc**________________

Weight:_________☐**lbs** ☐**KG** **Allergies**: ☐**None List** ____

Relevant History: ☐**Pregnant** ☐**HTN** ☐**Diabetes** ☐**Heart Disease** ☐**Stroke** ☐ **TB** ☐**HIV** ☐**Malaria**

Other Relevant History: ____

CHIEF COMPLAINTS:____

____

SPIRITUAL / EMOTIONAL:____

____

EXAM FINDINGS:____

____

DIAGNOSIS:

TREATMENT(s) RECOMMENDED:

Medication	Strength	Quantity	Directions	Duration	Condition Treated

Special Information / Instructions:____

____

Provider(s):____