

$\frac{20}{200}$

E

$\frac{200 \text{ FT.}}{61 \text{ M}}$

1

$\frac{20}{100}$

F P

$\frac{100 \text{ FT.}}{30.5 \text{ M}}$

2

$\frac{20}{70}$

T O Z

$\frac{70 \text{ FT.}}{21.3 \text{ M}}$

3

$\frac{20}{50}$

L P E D

$\frac{50 \text{ FT.}}{15.2 \text{ M}}$

4

$\frac{20}{40}$

P E C F D

$\frac{40 \text{ FT.}}{12.2 \text{ M}}$

5

$\frac{20}{30}$

E D F C Z P

$\frac{30 \text{ FT.}}{9.14 \text{ M}}$

6

$\frac{20}{25}$

F E L O P Z D

$\frac{25 \text{ FT.}}{7.62 \text{ M}}$

7

$\frac{20}{20}$

D E F P O T E C

$\frac{20 \text{ FT.}}{6.10 \text{ M}}$

8

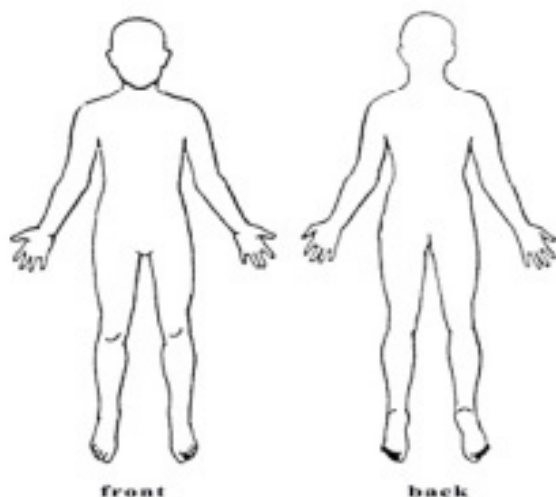


Patient Form

Please fill out the following form. Give the form to the Doctor when your name is called

Name of Patient: _____

Please circle the parts of your body where you feel pain



On a scale of 1 to 10 how bad is the pain?



When did the pain begin? _____

Please circle Y for YES or N for NO for the following questions:

Do you have a fever? Y N

Do you have trouble breathing? Y N

Do you have a headache? Y N

Do you have a rash? Y N If so, where? _____

Do you feel dizzy? Y N

If yes, when? (please circle) All Day In the Morning In the Evening At Night

Are you on any medications? Y N

If yes, what kind? _____

Anything else you want to tell the Doctor? _____



Physical Exam

Name of Patient: _____

MEASUREMENTS

Height: _____
 Head Circumference: _____
 Leg Length:
 Right: _____ Left: _____
 Arm Length:
 Right: _____ Left: _____

WEIGHT: _____

RESTING HEART RATE: (circle) 75bpm good 120bpm high 50bpm low

BLOOD PRESSURE: (circle) 120/80 good 140/95 high 110/67 low

CHECK EACH AREA



THROAT: (circle)
 Swollen Left Tonsil Red Bumps
 Swollen Right Tonsil White Bumps
 Both Tonsils Swollen Healthy



LUNGS: (circle)
 Wheezy Difficulty Breathing
 Asthmatic Congested (Wet)
 Coughing Healthy



LEFT EYE: (circle)	RIGHT EYE: (circle)
Red Swollen	Red Swollen
Pink Eye Stye	Pink Eye Stye
Watery Healthy	Watery Healthy



LEFT EAR: (circle)	RIGHT EAR: (circle)
Hearing Loss	Hearing Loss
Fluid Red	Fluid Red
Swollen Healthy	Swollen Healthy

NOTES:



Dr. Kid's Family Practice

emergency care open 24 hours
will make house calls

Rx

write prescription name & notes here

25 50 75 100

1 2 3

_____ doses _____ times a:(circle) DAY WEEK

EXTRA ADVISE:
(circle applicable)



PHARMACY: Walmart



TARGET



COSTCO

Doctor: _____ Date: _____
Signature: _____



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