ZealthCare Medical Clinic

Internal Medicine/Pediatrics

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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