

St. Czianna  
Family Medicine

Patient form

Patient name: \_\_\_\_\_



Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

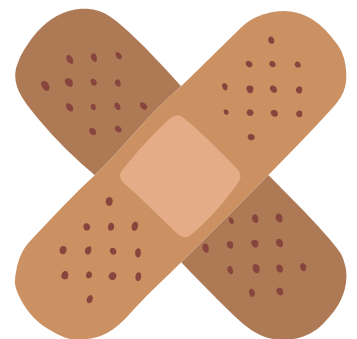
weight \_\_\_\_\_

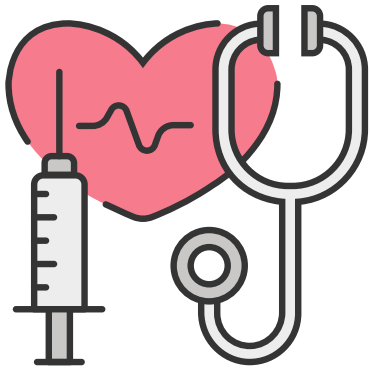
height \_\_\_\_\_

gender:    

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Reason for visit:





# St. Cyrianna Family Medicine

Physical exam

Date: \_\_\_\_\_

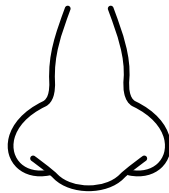
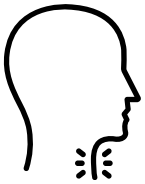
Patient name: \_\_\_\_\_

weight \_\_\_\_\_

height \_\_\_\_\_

blood pressure \_\_\_\_\_

temperature \_\_\_\_\_



Notes:

no

yes



PRESCRIPTIONS

Patient's name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Date: \_\_\_\_\_



Doctor's signature: \_\_\_\_\_