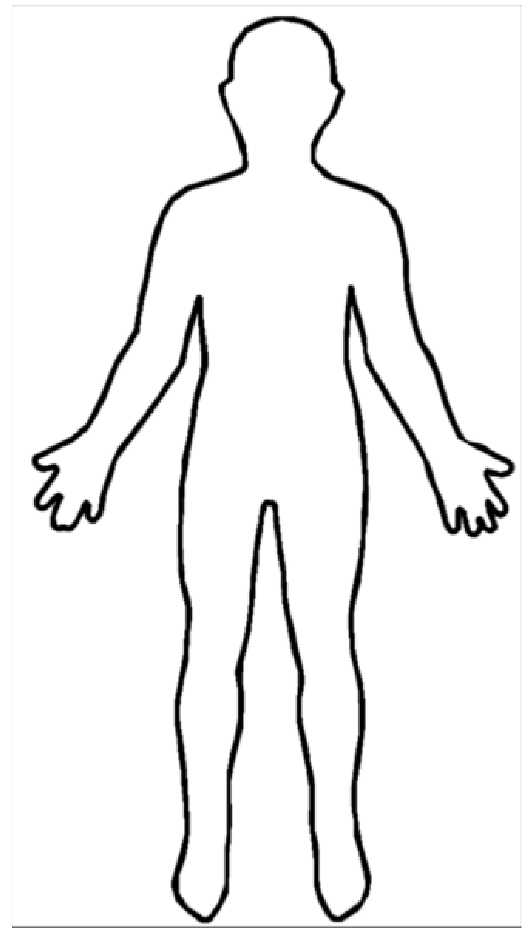
Patient's Name: ______________________



Mark where you have pain or discomfort.

Complaint / Reason for Exam (please circle)

- High Fever
- Sore Throat
- Ear Ache
- Tummy Ache
- Toothache
- Cut
- Broken Arm
- Broken Leg
- Check-Up

____

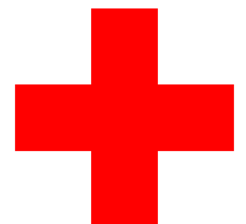
Doctor's Name: ______________________

Tests Recommended (Please circle)

X-Ray	MRI	Ultrasound	CT Scan
EEG	EKG	Blood Test	Eye Exa

Treatment Recommended:

Bandaid	Cast	Crutches
Shot	Sling	Medicine
Rest	Vitamins	Vacation



Doctor's Name: ______________________

Patient's Name: ______________________

Treatment Administered in Clinic:

Bandaid	Cast	Crutches
Shot	Sling	Medicine

Follow-Up Treatment

Exercise	Healthy Food	Hugs	Milkshake
Rest	Lots of Water	Kisses	A Vacation

Doctor's Name: ______________________

Patient's Name: ______________________

Treatment Administered in Clinic:

Bandaid	Cast	Crutches
Shot	Sling	Medicine

Follow-Up Treatment

Exercise	Healthy Food	Hugs	Milkshake
Rest	Lots of Water	Kisses	A Vacation

Patient's Name: ______________________

Mark where you have pain or discomfort.

Headache

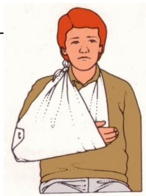
Earache

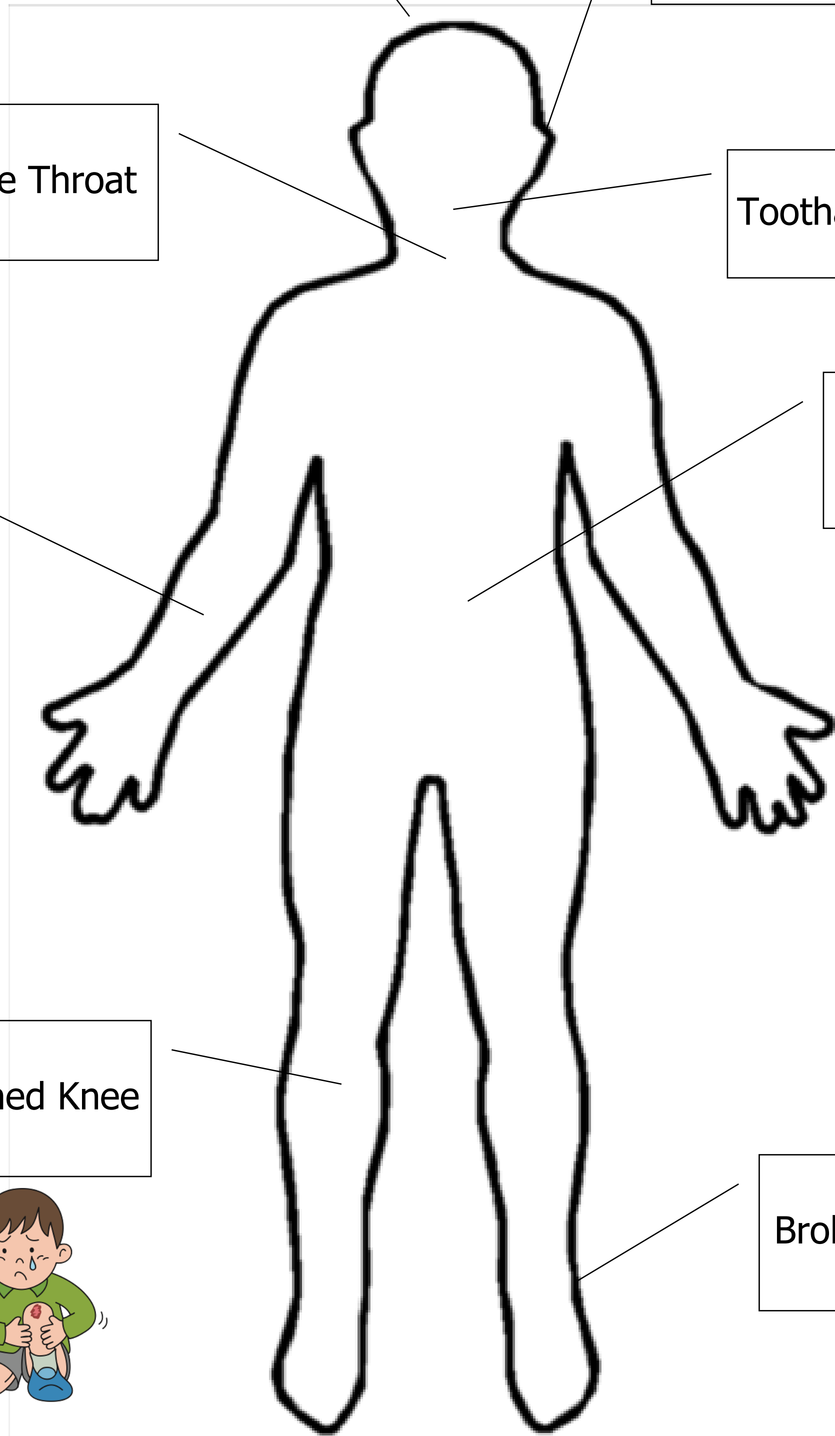
Sore Throat

Toothache

Upset Tummy

Broken Arm

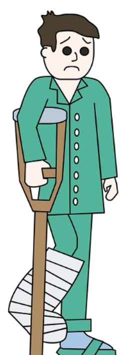




Hurt Finger

Skinned Knee

Broken Ankle



Patient's Name: ______________________

Mark where you have pain or discomfort.

Headache

Earache

Sore Throat

Toothache

Upset Tummy

Broken Arm

Hurt Finger

Skinned Knee

Broken Ankle