ADULT FLOWSHEET AND MEDICATIONS

Patient Name: _____

Date of Birth: _____

Allergies: ☐ No ☐ Yes (If Yes, See Adult Summary Form)

Problems: (Optional)

Date												
Height / Weight												
Blood Pressure												
Pulse												
Temperature / RR												
Tobacco: C, F, N / Counseling (Current, Former, Never) (Y/N)												
Fingerstick / HbA1c												
Total Chol. / LDL / HDL												

Medication Dose / Route Frequency												
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