

**Nom De Famille:** \_\_\_\_\_ **Prenom:** \_\_\_\_\_ **Date De Naissance: (J/M/A)** \_\_\_\_\_

**Sexe:** H/F **L'Age:** \_\_\_\_\_ **Paran (pou timoun) oswa yon kontak ijans** \_\_\_\_\_ **Telefòn** \_\_\_\_\_  
Parent (for children) or emergency contact

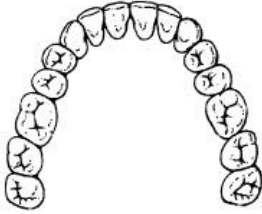
**Adresse:** \_\_\_\_\_ **Telefòn** \_\_\_\_\_

**HX** (Circle) HTN DM Seizures Asthma Anemia GERD Other: \_\_\_\_\_

**Vaccinations:** TDap Hep A/B Polio MMR BHG **OB/GYN:** P G A **Kantite moun ki vivan** \_\_\_\_\_  
(Number of living children)

**Medications:** \_\_\_\_\_

**DATE:** \_\_\_\_\_ **BP:** \_\_\_\_\_ **HR:** \_\_\_\_\_ **Resp:** \_\_\_\_\_ **Temp:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ kg \_\_\_\_\_ lb



**Retounen nan klinik** (Return to Clinic) **Date:** \_\_\_\_\_ **Doktè** (Doctor) \_\_\_\_\_

**DATE:** \_\_\_\_\_ **BP:** \_\_\_\_\_ **HR:** \_\_\_\_\_ **Resp:** \_\_\_\_\_ **Temp:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ kg \_\_\_\_\_ lb



**Retounen nan klinik** (Return to Clinic) **Date:** \_\_\_\_\_ **Doktè** (Doctor) \_\_\_\_\_

**DATE:** \_\_\_\_\_ **BP:** \_\_\_\_\_ **HR:** \_\_\_\_\_ **Resp:** \_\_\_\_\_ **Temp:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ kg \_\_\_\_\_



**Retounen nan klinik** (Return to Clinic) **Date:** \_\_\_\_\_

**Doktè** (Doctor) \_\_\_\_\_

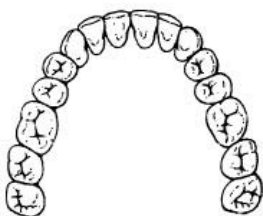
**DATE:** \_\_\_\_\_ **BP:** \_\_\_\_\_ **HR:** \_\_\_\_\_ **Resp:** \_\_\_\_\_ **Temp:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ kg \_\_\_\_\_ lb



**Retounen nan klinik** (Return to Clinic) **Date:** \_\_\_\_\_

**Doktè** (Doctor) \_\_\_\_\_

**DATE:** \_\_\_\_\_ **BP:** \_\_\_\_\_ **HR:** \_\_\_\_\_ **Resp:** \_\_\_\_\_ **Temp:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ kg \_\_\_\_\_ lb



**Retounen nan klinik** (Return to Clinic) **Date:** \_\_\_\_\_

**Doktè** (Doctor) \_\_\_\_\_