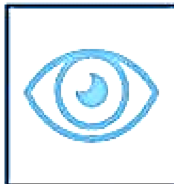
SQUIZZEL FAMILY CLINIC

PATIENT EXAMINATION FORM

PATIENT NAME: ______________________________

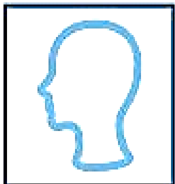
WHAT HURTS:


EYE ☐

EAR ☐

NOSE ☐

MOUTH ☐

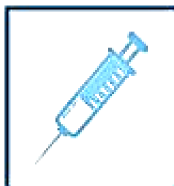

HEAD ☐

SYMPTOMS:

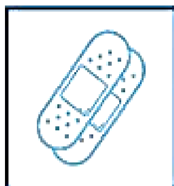
☐ BODY ACHE	☐ FEVER	☐ SNEEZING
☐ COUGHING	☐ HEADACHE	☐ STOMACH ACHE
☐ CUT	☐ RED EYES	☐ OTHER

DIAGNOSIS: ______________________________

TREATMENT:


SHOT ☐

MEDICINE ☐


BANDAID ☐

REST ☐

EYE DROPS ☐

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doctor's signature