DOSAGE BLANKS—for giving medicines to those who cannot read (see p. 64)
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Where There Is No Doctor 2017
PATIENT REPORT
TO USE WHEN SENDING FOR MEDICAL HELP

Name of the sick person: __________________________________________ Age: _____

Male ______ Female______ Where is he (she)? ________________________________

What is the main sickness or problem right now? __________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

When did it begin? __________________________________________________________

How did it begin? ___________________________________________________________

Has the person had the same problem before? _______When? ________________

Is there fever? _______ How high? _______ ° When and for how long? ___________

Pain? _______ Where? _______________________ What kind?____________________

What is wrong or different from normal in any of the following?

Skin: ______________________________________ Ears: ____________________________

Eyes: ______________________________________ Mouth and throat: __________________

Genitals: ______________________________________

Urine: Much or little? ___________ Color? ___________ Trouble urinating?____

Describe: _______________________________ Times in 24 hours: ______ Times at night: ___

Stools: Color? ______________ Blood or mucus? __________ Diarrhea? ______

Number of times a day: _______ Cramps? _______ Dehydration? ______ Mild or severe? ____________ Worms? ________ What kind? _______________

Breathing: Breaths per minute: _________ Deep, shallow, or normal? ______

Difficulty breathing (describe): ___________________________ Cough (describe): _____

_____________________________ Wheezing? _______ Mucus? _________ With blood? _____

Does the person have any of the SIGNS OF DANGEROUS ILLNESS listed on
page 42? _______ Which? (give details) ___________________________________________

_______________________________________________________________

Other signs: ________________________________________________________

Is the person taking medicine? _______ What? ____________________________

Has the person ever used medicine that has caused a rash, hives (or bumps)
with itching, or other allergic reactions? _______ What? _______________________

The state of the sick person is: Not very serious: _______________ Serious: ______

Very serious: ______________________

On the back of this form write any other information you think may be important.
PATIENT REPORT
TO USE WHEN SENDING FOR MEDICAL HELP

Name of the sick person: __________________________________________ Age: ___
Male _______ Female _______ Where is he (she)? ____________________________
What is the main sickness or problem right now? ____________________________
_________________________________________________________________________
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_________________________________________________________________________
When did it begin? _________________________________________________________
How did it begin? __________________________________________________________
Has the person had the same problem before? _______ When? _______________
Is there fever? _______ How high? _______ ° When and for how long? ___________
Pain? _______ Where? _______________________ What kind? ___________________

What is wrong or different from normal in any of the following?

Skin: __________________________________________ Ears: _________________________
Eyes: ______________________________________ Mouth and throat: ___________________
Genitals: ___________________________________ Urine: Much or little? _________ Color? _________ Trouble urinating? ___
Describe: ___________________________________ Times in 24 hours: ______ Times at night: ___
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PATIENT REPORT
TO USE WHEN SENDING FOR MEDICAL HELP

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Male ____ Female _______ Where is he (she)? _________________________________

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