DOSAGE BLANKS—for giving medicines to those who cannot read (see p. 64)
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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): __________________________________________
______________________________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)? ________________________________
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When did it begin? __________________________________________________________
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Pain? _________ Where? _______________________ What kind? ______________________

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

Skin: ____________________________________________ Ears: __________________________
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Genitals: __________________________________________ Urine: ________________________________
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Describe: ___________________________ Times in 24 hours: _______ Times at night: ______
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Number of times a day: _________ Cramps? _________ Dehydration? _________ Mild or severe? _________ Worms? ___________ What kind? ______________________
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Difficulty breathing (describe): ___________________________ Cough (describe): ______
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