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)? ________________________________
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): _______________________________________________________________________

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? ____________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
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? ______________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
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?_____________

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: ______________________________________________________________
INFORMATION ON VITAL SIGNS

TEMPERATURE

There are two kinds of thermometer scales: Centigrade (C) and Fahrenheit (F). Either can be used to measure a person’s temperature in degrees (40˚ means 40 degrees). See p. 31.

Here is how they compare:

**CENTIGRADE**

This thermometer reads 40˚C (Forty degrees Centigrade)

below 35˚C  TOO LOW

37˚C  NORMAL

above 39˚C  HIGH

**FAHRENHEIT**

This thermometer reads 104˚ F (104 degrees Fahrenheit)

below 95˚ F  TOO LOW

98.6˚F  NORMAL

above 102˚ F  HIGH

PULSE OR HEARTBEAT

For a person at rest, 60 to 80 beats per minute is normal.

- ADULTS: . . . . . . . . . . 60 to 80 beats per minute is normal.
- CHILDREN: . . . . . 80 to 100 beats per minute is normal.
- BABIES: . . . . . . . . 100 to 140 beats per minute is normal.
- NEWBORNS: . . . 120 to 160 beats per minute is normal.

For each degree Centigrade (C) of fever, the heartbeat usually increases about 20 beats per minute.

RESPIRATION

For a person at rest:

- ADULTS AND OLDER CHILDREN: .12 to 20 breaths per minute is normal.
- CHILDREN: . . . . . . . . up to 30 breaths per minute is normal.
- BABIES: . . . . . . . . . up to 40 breaths per minute is normal.
- NEWBORNS: . . . . . . 30 to 60 breaths per minute is normal.

More than 40 shallow breaths a minute usually means pneumonia (see p. 171) for a child or an adult. For babies, 50–60 breaths per minute probably means pneumonia.

BLOOD PRESSURE (This is included for health workers who have the equipment to measure blood pressure.)

For a person at rest, 120/80 is normal, but this varies a lot.

If the first reading (when the sound begins), is over 160, or if the second reading (when the sound disappears), is over 100, this is a danger sign of high blood pressure (see p. 125).