





















DOSAGE BLANKS—for giving medicines to those who cannot read (see p. 64)





			
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


			
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


			
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


			
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








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


			
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


			
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


			
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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): \_\_\_\_\_ 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)? \_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

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