



VITAL SIGNS

Patient Name _____

Date of Birth: _____ Sex _____

Height :

Weight:

Did you measure client? Yes / No

Did you weigh client? Yes / No

Time	1. Left arm	2. Right arm	Pulse
Systolic			
Diastolic			Irregularities Y / N

Signature of Client _____

Signature of Examiner _____

DATE: _____