



VITAL SIGNS

Patient Name: _____

Date of Birth: _____ Sex: _____

Height:

Weight:

Did you remember to measure the client? Yes / No

Did you weigh the client? Yes / No

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

Males Only Chest Expanded Chest Contracted Abdomen at umbilicus

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Signature of Client _____

Signature of Examiner _____

Date: _____

FAX COMPLETED FORM TO 1-877-410-5522

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