

Play Literacy Doctor's Office

Patient's Name: _____

Patient's Address: _____

Patient's Age: _____ Phone # _____

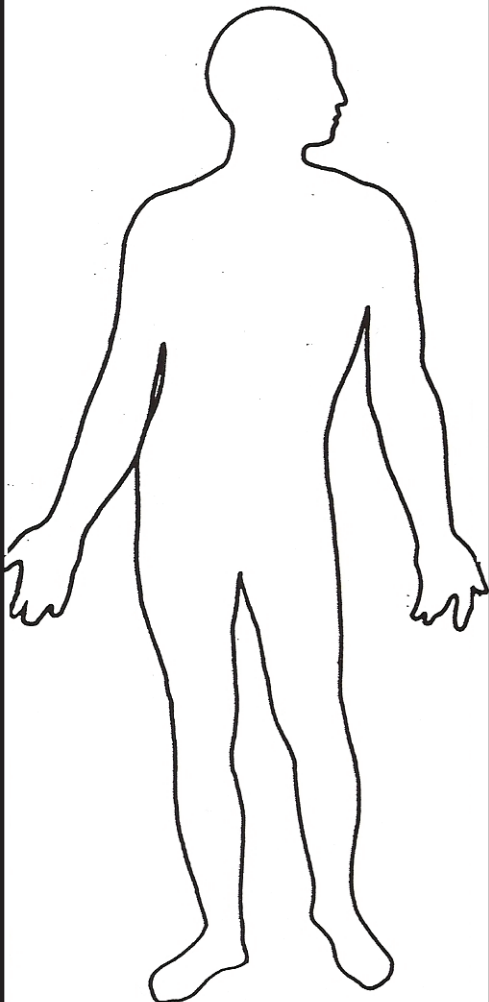
Height: _____ Weight: _____

Doctor's Name: _____ Today's Date: _____

Reason for Visit: Check Up Accident Vaccination Illness

Physical Examination

Circle the areas of the body affected:



Temperature

- Normal
- High
- Low



Blood Pressure

- Normal
- High
- Low



Heartbeat

- Normal
- High
- Low



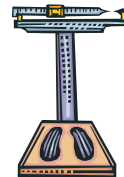
Throat

- Normal
- Swollen



Ears

- Normal
- Waxy



Weight

- Normal
- Heavy
- Light

Doctor's Recommendations:

Medication _____

Special Diet _____

Rest _____

See Specialist _____

Blood Tests _____

Operation _____