|  |  |  |  |
| --- | --- | --- | --- |
| **PATIENT NAME:** | ${name} | **BIRTHDATE:** | ${bdate} |
| **GENDER:** | ${gender} | **ADDRESS:** | ${address} |
| **MOTHER’S NAME:** | ${mother} | **FATHER’S NAME:** | ${father} |

**DATE OF CONSULT:** ${date}

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **WEIGHT** | ${weight} | **HEIGHT** | ${height} | **BLOOD PRESSURE** | ${bp} |

**VITAMINS / SUPPLEMENTS / MEDICATION:**

${med\_intake}

**HISTORY: PHYSICAL FINDINGS / DIAGNOSIS / TREATMENT:**

${history}

**VACCINE RECEIVED:**

${vaccine}

**Prescribe by:**

DR. GERALDINE GAY E. FRILLES

Pediatrician

**DATE: ${dateNow}**