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Advance Medical Home Physicians
Surgery of the Skin, Wound Care, Burn Care
Pain Management, & General Practice
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VITALS FLOW SHEET

MONTH OF_____ YEAR_____ Pt height __'__"

PATIENT NAME:

Date of the month that vitals were done	Temp in degrees Farenheit	Pulse in beats per minute	Resp. in # of breaths per min	Blood Pressure in mmHg systolic / diastolic	O2 sat. %	Pain Score on 11 point scale 0 = no pain 10 = worst pain patient has ever experienced	Weight in pounds	Name of person who took the vitals & person's title (RN, LPN, PT, OT) PLEASE PRINT NAME & TITLE
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2nd								
3rd								
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