McLAREN AMBULATORY CARE CENTER

PATIENT VITALS AND HEALTH MAINTENANCE

Patient Name: _____ **DOB:**_____

Date:											
BP											
Pain Level											
TEMP											
Pulse											
Respiration											
Weight											
Height*											
Initials											

* Required Annually

Date:											
BP											
Pain Level											
TEMP											
Pulse											
Respiration											
Weight											
Height*											
Initials											

* Required Annually

Health Habits	Yes	No	Amount
Tobacco Use			
Alcohol Use			
Caffeine Use			
Addictive/Illicit Drug Use			
Seat Belt Use			
Education Materials Provided:			

Health Maintenance					
Procedure	Date	Date	Date	Date	Date