

# ANNUAL VITALS

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

☐ Patient identity verified with Driver's License or State ID (*examiner's initials required*) \_\_\_\_\_

## VITAL SIGNS:

Height:	
Weight:	
B/P:	
Heart Rate:	

Examiner Printed Name: \_\_\_\_\_

Examiner Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE FAX TO (561) 658-6212