



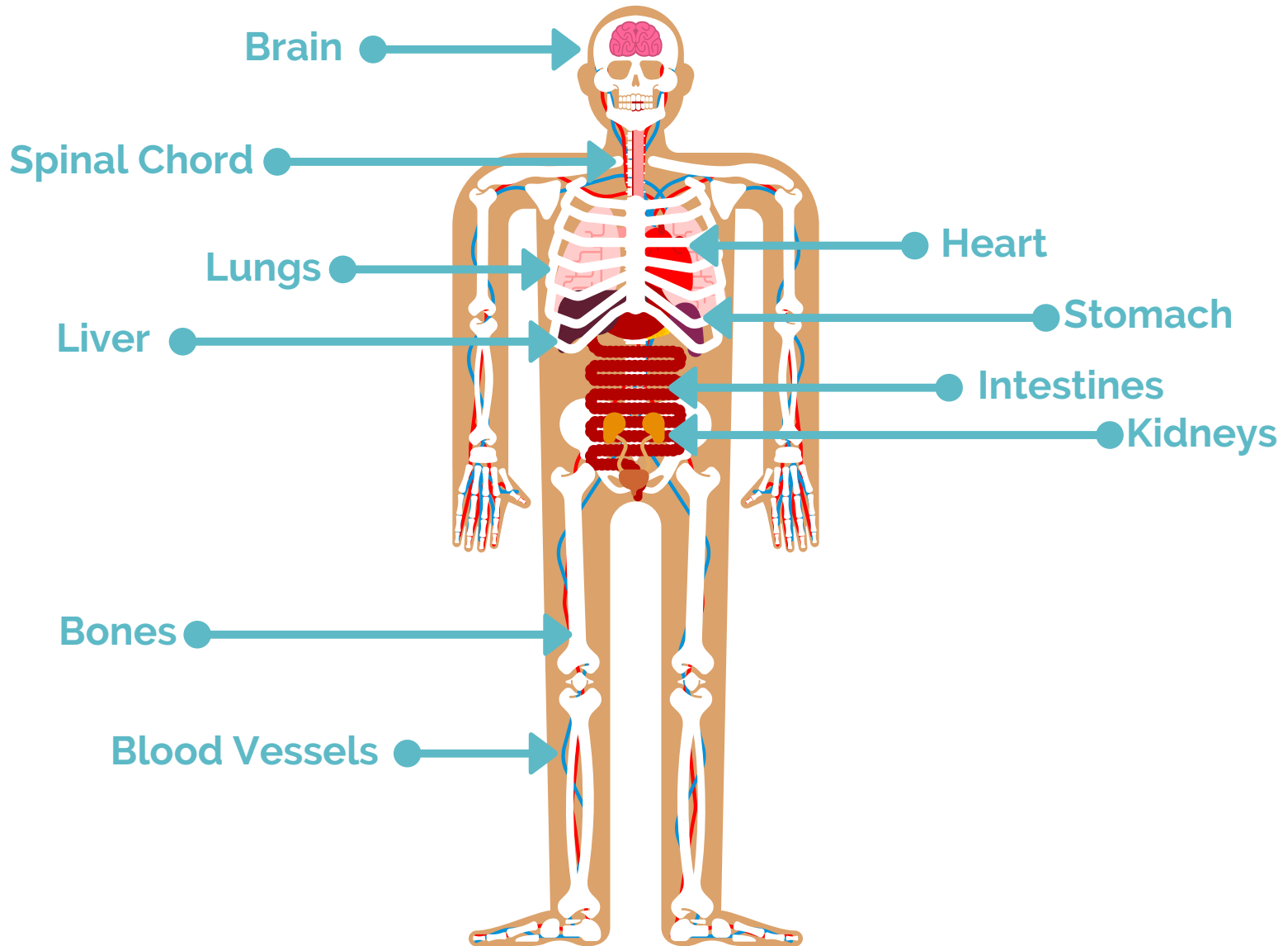
Doctor's Name:

Patient's Name:

How are you feeling today?



Circle the body part that needs a checkup today.



Treatment:



EYE EXAM

E

F

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E

C

F

D

E

D

F

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L

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Z

D

D

E

F

P

O

T

E

C

Prescription

Patient's Name: _____

Address: _____

Date: _____

Refill: _____ times

Rx

Doctor's Signature

Prescription

Patient's Name: _____

Address: _____

Date: _____

Refill: _____ times

Rx

Doctor's Signature