AST Blood Test

Patient's full name:

Date of birth: **Age:**

Gender:

Medical record #:

Attending physician's full name:

Patient's medical history:

Symptoms

☐ Weakness	☐ Fatigue	☐ Nausea
☐ Vomiting	☐ Loss of appetite	☐ Weight loss
☐ Pain in belly	☐ Swelling in belly	☐ Jaundice
☐ Dark-colored urine	☐ Light-colored stool	☐ Itchy skin

Other symptoms:

AST Blood Test Results

☐ Male ☐ Female

AST blood count: _____ units/L

☐ **Normal**

☐ **Mild elevation**

☐ **Severe elevation**

Comments