CBC Blood Test

Patient's full name:

Date of birth: **Age:** **Gender:**

Medical record #:

Attending physician's full name:

Patient's medical history:

Symptoms

☐ Bruises	☐ Bleeding	☐ Weakness
☐ Fatigue	☐ Fever	☐ Headaches
☐ Dizziness	☐ Nausea	☐ Vomiting
☐ Joint pains	☐ Inflammations	☐ Abnormal heart rate
☐ High blood pressure	☐ Low blood pressure	

Other symptoms:

CBC Blood Test Results

NOTE: Please indicate your lab's normal values per component, especially for your patient's gender.

Component	Results (include units)	Normal Ranges
Red Blood Cell Count (Erythrocytes)		
Hemoglobin		
Hematocrit		
Erythrocyte Sedimentation Rate		
Red Cell Distribution Width		
White Blood Cell Count (Leukocytes)		
Monocyte Count		
Lymphocyte Count		
Neutrophil Count		
Basophil Count		
Eosinophil Count		
Platelet Count (Thrombocytes)		
Mean Corpuscular Volume (MCV)		
Mean Corpuscular Hemoglobin (MCH)		
Mean Corpuscular Hemoglobin Concentration (MCHC)		

Comments

Your blood test results will be kept confidential.

Signed by: _____ (signature over printed name)

Date: _____