# Prescription Form

| Patient's Name | | Date of Consultation | |
|---|---|---|---|
| Sex | | Age | |
| Weight | | Height | |
| Blood Pressure | | Restriction/Allergies | |
| Diagnosis | | | |

## Medication

| | Generic/ Brand Name | Preparation/ Dosage/ Frequency/ Route | Timing | | | |
|---|---|---|---|---|---|---|
| | | | Morning | Afternoon | Evening | Bedtime |
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |
| 7 | | | | | | |
| 8 | | | | | | |

**Diet to Follow**

- ☐ Regular/Full
- ☐ Soft

- [ ] Low Salt
- [ ] Other: ___________________________________________________________

**Activity/Exercise**

- [ ] No Restriction
- [ ] With Restriction (specify): ___________________________________________________________

**Doctor's Recommendation**

- [ ] Follow-up appointment: ___________________________________________________________
- [ ] Additional Tests Required: ___________________________________________________________
- [ ] Other Instructions: ___________________________________________________________

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**Doctor's Signature:** ______________________________

**Doctors Name:** ______________________________