PHYSICAL HEALTH OBSERVATIONS

**Before commencing or before a repeat prescription is issued for your medication, the information below is required to ensure it is safe for you to continue on your current medication.**

**Please note that without this information, NO prescriptions will be issued.**

**Name :** ……………………………………………………………………….

**DoB :** ……………………………………………………………………….

**Blood pressure** ……………………………….

**Pulse rate** ……………………………….

**Height**  ……………………………….

**Weight**  ……………………………….

**Date observations were taken** ………………………………..

**Name of person recording observations** ……………………………….