

Physician Assessment Form

Patient Name: _____ YH Reg. Number: _____

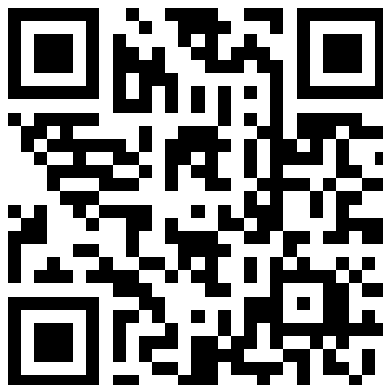
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

Respiratory Symptoms: Cough [], Wheezing [], Crackle [], Ronchi []

PFT Results(If Applicable): FVC: ____L, FEV1: ____L/sec, PEF: ____L/sec,

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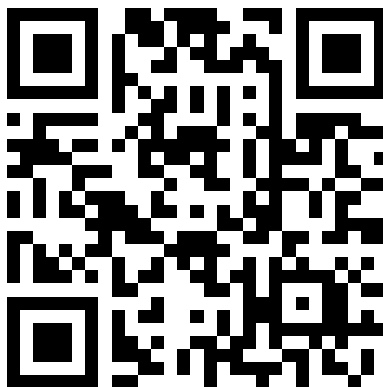
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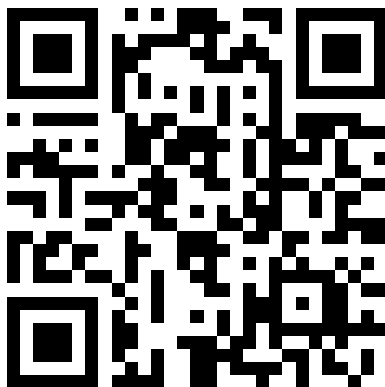
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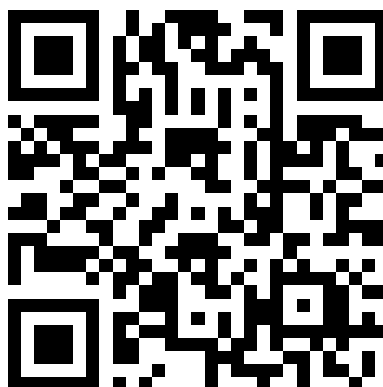
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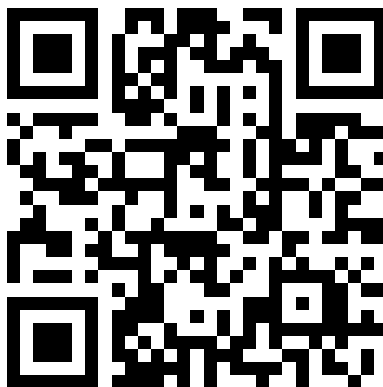
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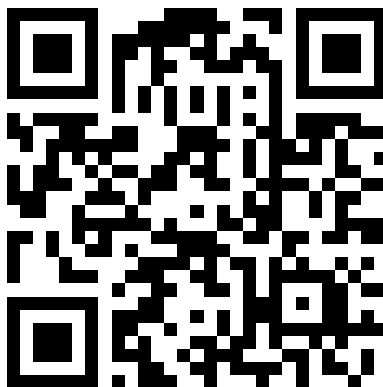
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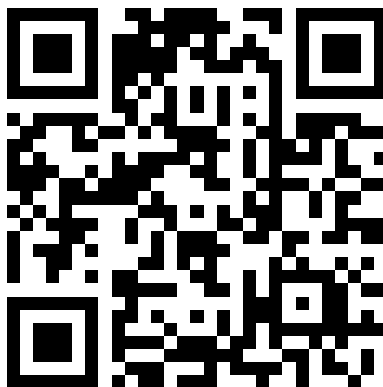
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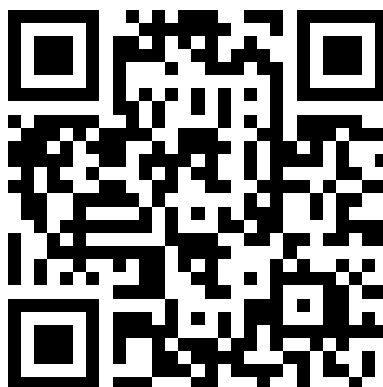
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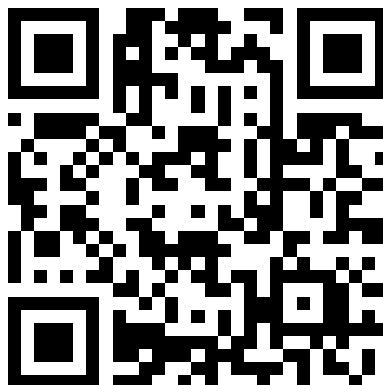
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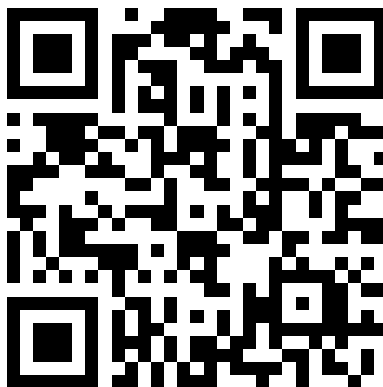
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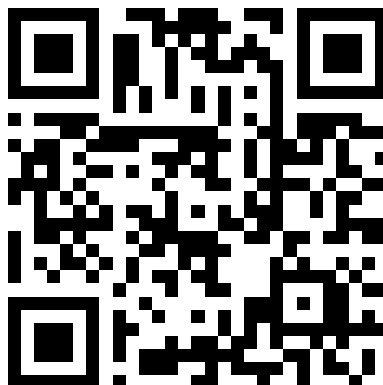
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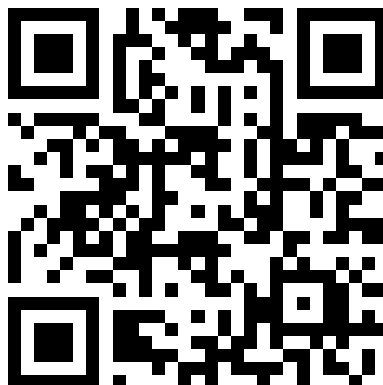
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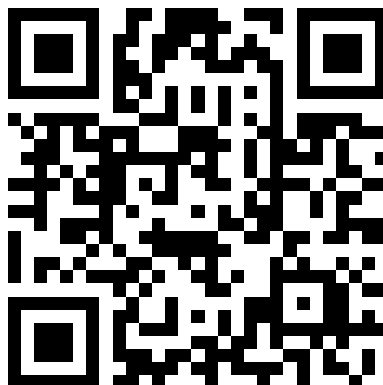
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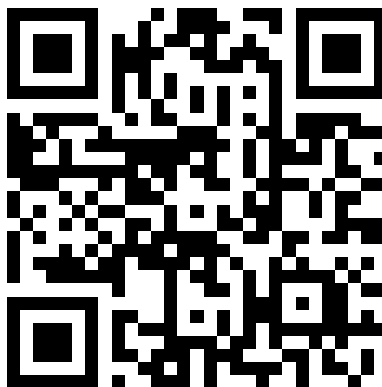
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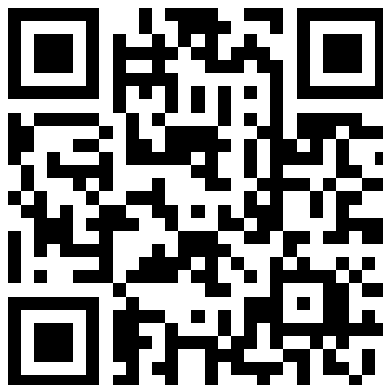
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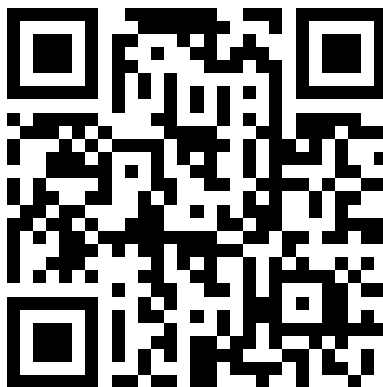
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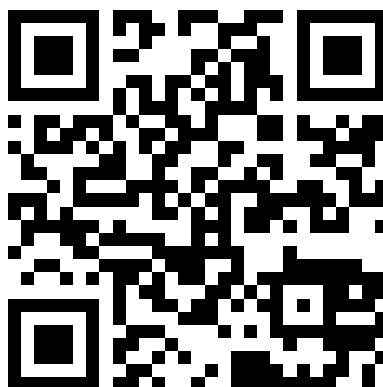
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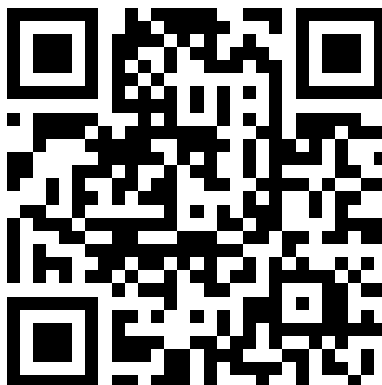
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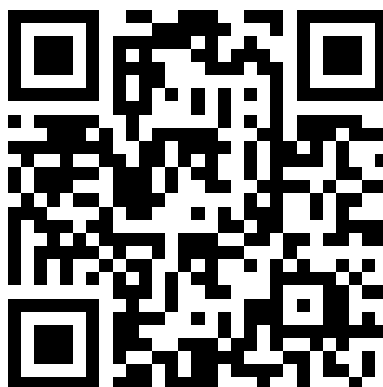
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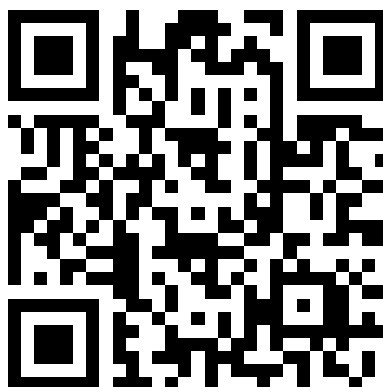
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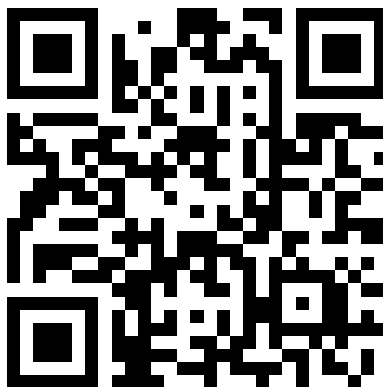
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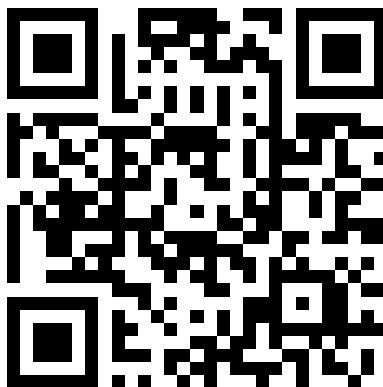
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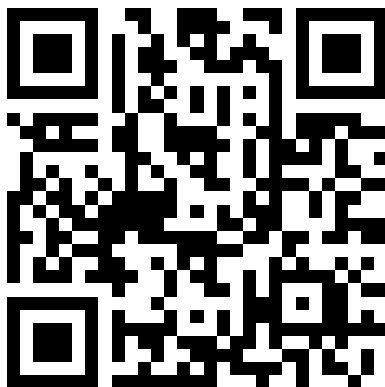
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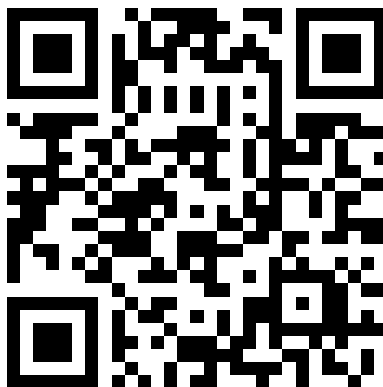
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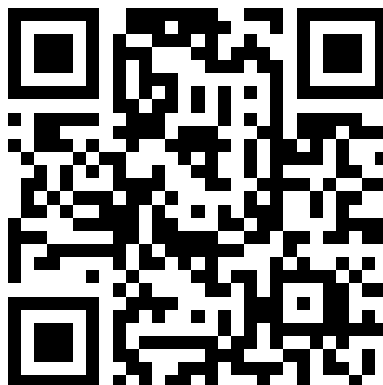
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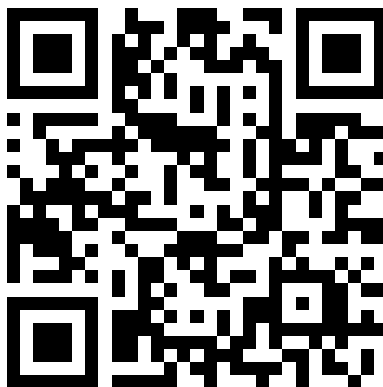
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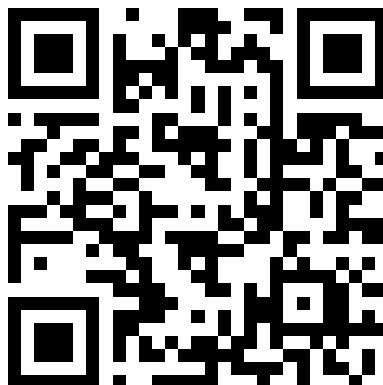
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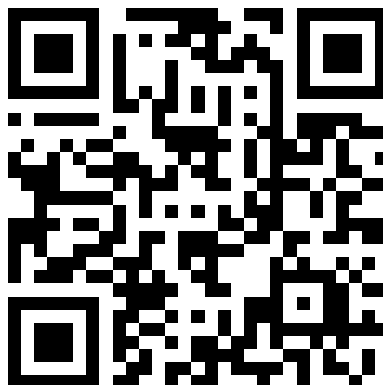
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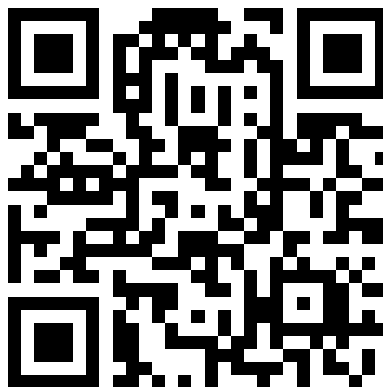
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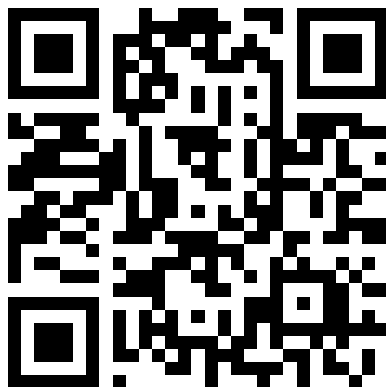
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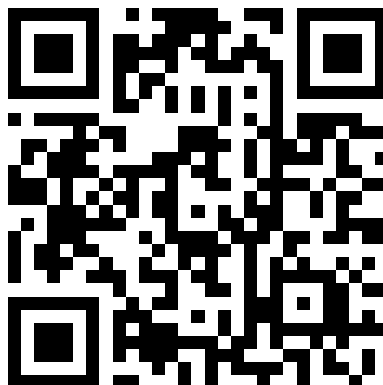
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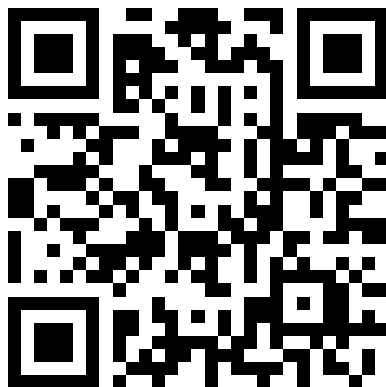
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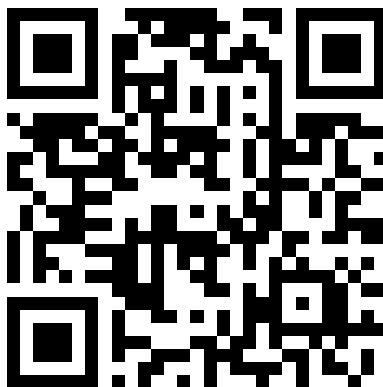
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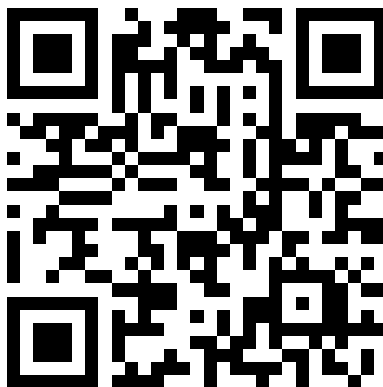
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PFT Results(If Applicable): FVC: ____L, FEV1: ____L/sec, PEF: ____L/sec,

Physician Assessment (if any):

Signature of Physician



Physician Assessment Form

Patient Name: _____ YH Reg. Number: _____

Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

Respiratory Symptoms: Cough [], Wheezing [], Crackle [], Ronchi []

PFT Results(If Applicable): FVC: ____L, FEV1: ____L/sec, PEF: ____L/sec,

Physician Assessment (if any):

Signature of Physician



Physician Assessment Form

Patient Name: _____ YH Reg. Number: _____

Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

Respiratory Symptoms: Cough [], Wheezing [], Crackle [], Ronchi []

PFT Results(If Applicable): FVC: ____L, FEV1: ____L/sec, PEF: ____L/sec,

Physician Assessment (if any):

Signature of Physician



Physician Assessment Form

Patient Name: _____ YH Reg. Number: _____

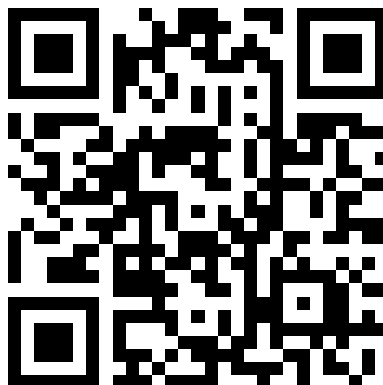
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

Respiratory Symptoms: Cough [], Wheezing [], Crackle [], Ronchi []

PFT Results(If Applicable): FVC: ____L, FEV1: ____L/sec, PEF: ____L/sec,

Physician Assessment (if any):

Signature of Physician



Physician Assessment Form

Patient Name: _____ YH Reg. Number: _____

Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

Respiratory Symptoms: Cough [], Wheezing [], Crackle [], Ronchi []

PFT Results(If Applicable): FVC: ____L, FEV1: ____L/sec, PEF: ____L/sec,

Physician Assessment (if any):

Signature of Physician



Physician Assessment Form

Patient Name: _____ YH Reg. Number: _____

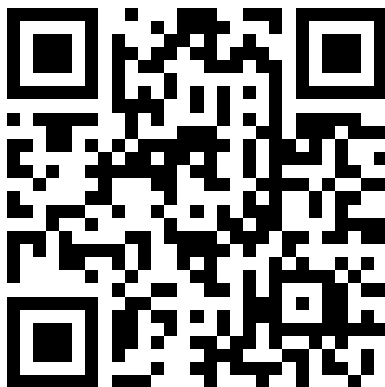
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Respiratory Symptoms: Cough [], Wheezing [], Crackle [], Ronchi []

PFT Results(If Applicable): FVC: ____L, FEV1: ____L/sec, PEF: ____L/sec,

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Signature of Physician



Physician Assessment Form

Patient Name: _____ YH Reg. Number: _____

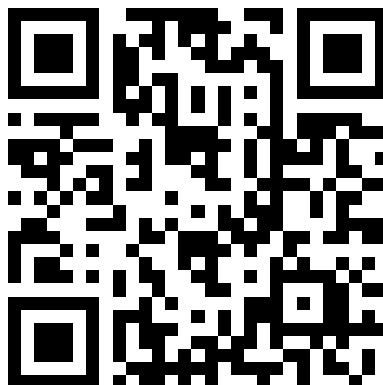
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

Respiratory Symptoms: Cough [], Wheezing [], Crackle [], Ronchi []

PFT Results(If Applicable): FVC: ____L, FEV1: ____L/sec, PEF: ____L/sec,

Physician Assessment (if any):

Signature of Physician



Physician Assessment Form

Patient Name: _____ YH Reg. Number: _____

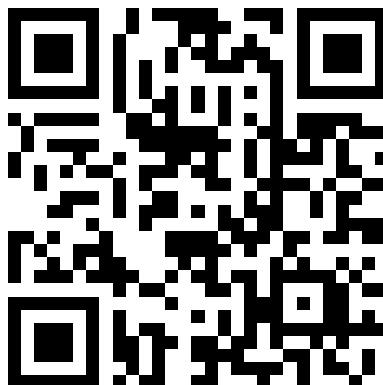
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

Respiratory Symptoms: Cough [], Wheezing [], Crackle [], Ronchi []

PFT Results(If Applicable): FVC: ____L, FEV1: ____L/sec, PEF: ____L/sec,

Physician Assessment (if any):

Signature of Physician



Physician Assessment Form

Patient Name: _____ YH Reg. Number: _____

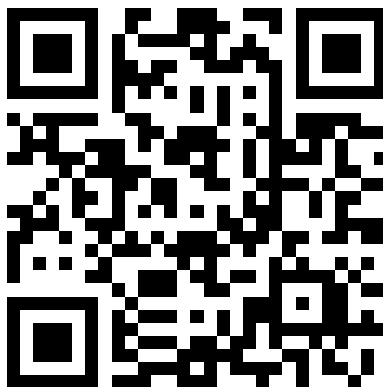
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

Respiratory Symptoms: Cough [], Wheezing [], Crackle [], Ronchi []

PFT Results(If Applicable): FVC: ____L, FEV1: ____L/sec, PEF: ____L/sec,

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Signature of Physician



Physician Assessment Form

Patient Name: _____ YH Reg. Number: _____

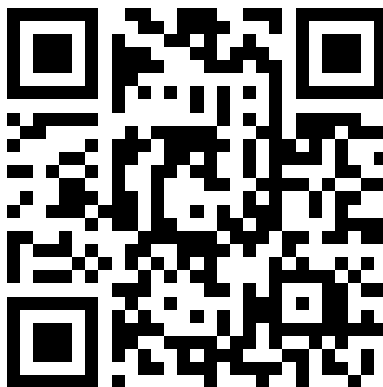
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

Respiratory Symptoms: Cough [], Wheezing [], Crackle [], Ronchi []

PFT Results(If Applicable): FVC: ____L, FEV1: ____L/sec, PEF: ____L/sec,

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Signature of Physician



Physician Assessment Form

Patient Name: _____ YH Reg. Number: _____

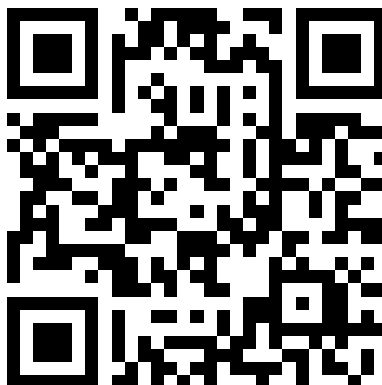
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Respiratory Symptoms: Cough [], Wheezing [], Crackle [], Ronchi []

PFT Results(If Applicable): FVC: ____L, FEV1: ____L/sec, PEF: ____L/sec,

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Physician Assessment Form

Patient Name: _____ YH Reg. Number: _____

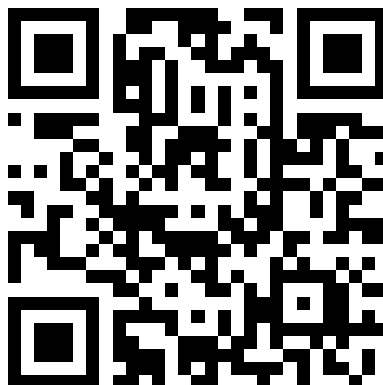
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

Respiratory Symptoms: Cough [], Wheezing [], Crackle [], Ronchi []

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Physician Assessment Form

Patient Name: _____ YH Reg. Number: _____

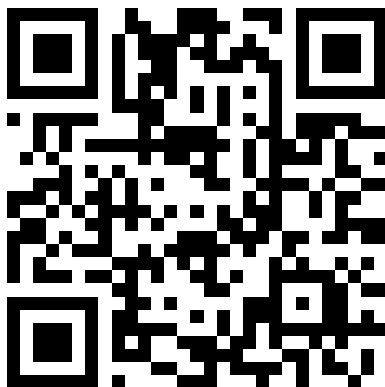
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

Respiratory Symptoms: Cough [], Wheezing [], Crackle [], Ronchi []

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Physician Assessment Form

Patient Name: _____ YH Reg. Number: _____

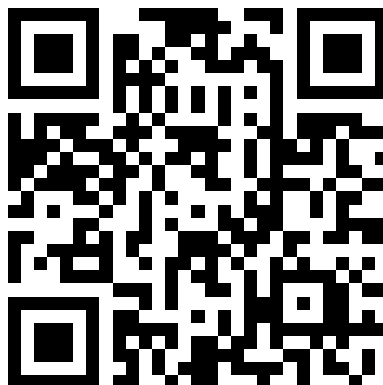
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

Respiratory Symptoms: Cough [], Wheezing [], Crackle [], Ronchi []

PFT Results(If Applicable): FVC: ____L, FEV1: ____L/sec, PEF: ____L/sec,

Physician Assessment (if any):

Signature of Physician



Physician Assessment Form

Patient Name: _____ YH Reg. Number: _____

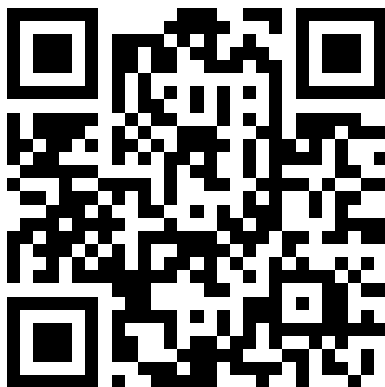
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

Respiratory Symptoms: Cough [], Wheezing [], Crackle [], Ronchi []

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Physician Assessment Form

Patient Name: _____ YH Reg. Number: _____

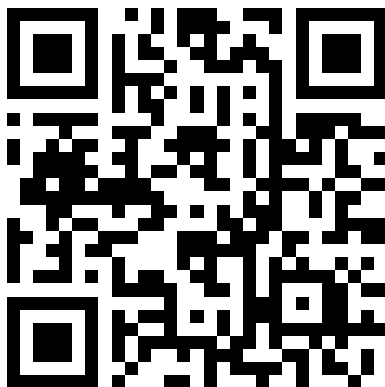
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

Respiratory Symptoms: Cough [], Wheezing [], Crackle [], Ronchi []

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Physician Assessment Form

Patient Name: _____ YH Reg. Number: _____

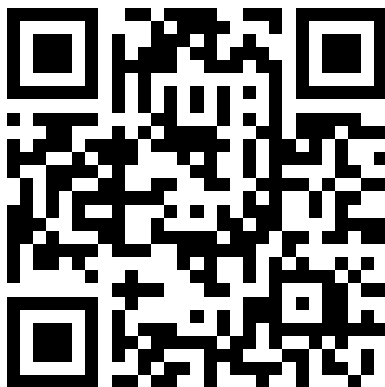
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

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Physician Assessment Form

Patient Name: _____ YH Reg. Number: _____

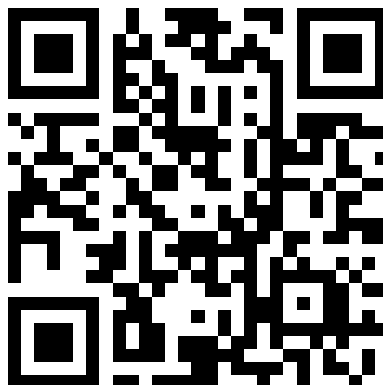
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

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Physician Assessment Form

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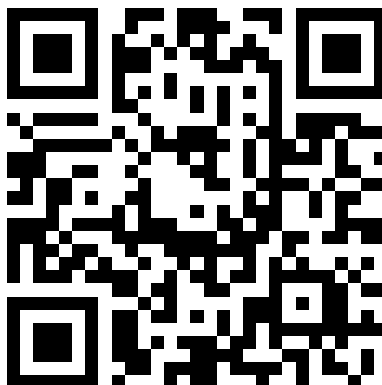
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

Respiratory Symptoms: Cough [], Wheezing [], Crackle [], Ronchi []

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Physician Assessment Form

Patient Name: _____ YH Reg. Number: _____

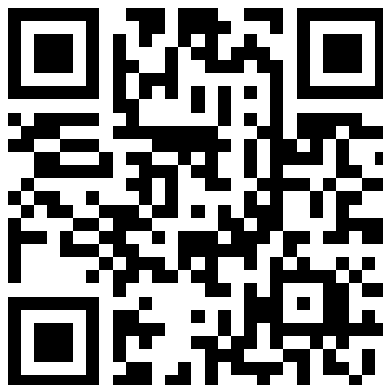
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

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Physician Assessment Form

Patient Name: _____ YH Reg. Number: _____

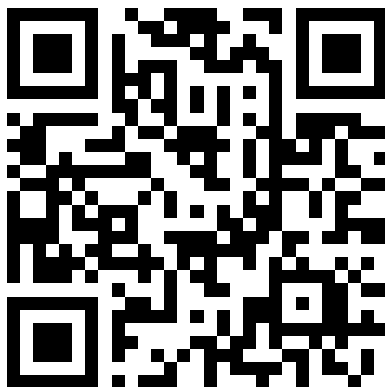
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

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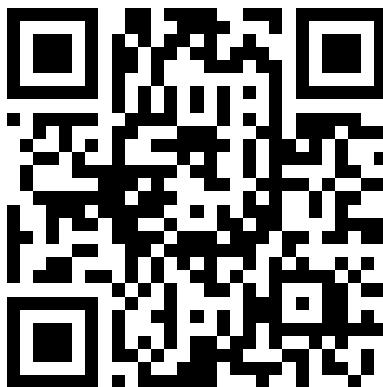
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

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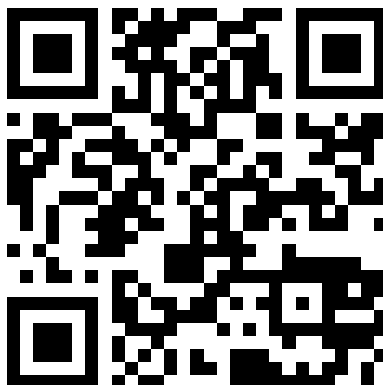
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

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Physician Assessment Form

Patient Name: _____ YH Reg. Number: _____

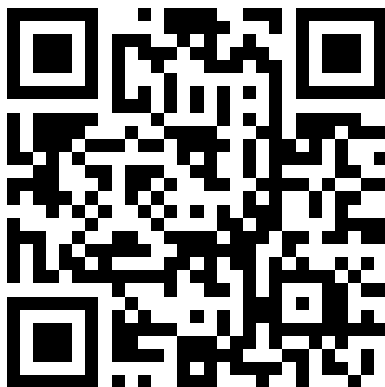
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

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Physician Assessment Form

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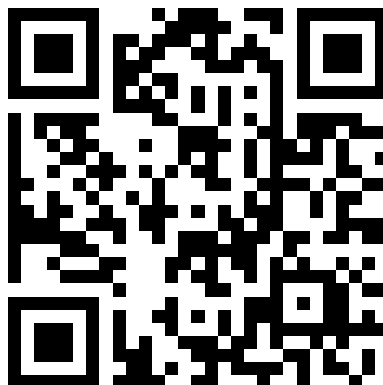
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

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Physician Assessment Form

Patient Name: _____ YH Reg. Number: _____

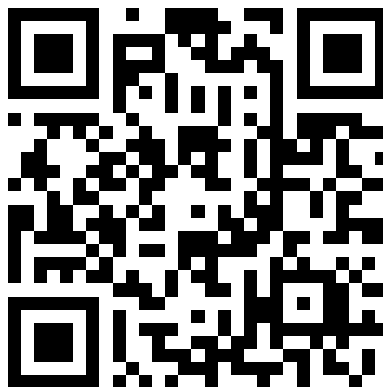
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

Respiratory Symptoms: Cough [], Wheezing [], Crackle [], Ronchi []

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Signature of Physician



Physician Assessment Form

Patient Name: _____ YH Reg. Number: _____

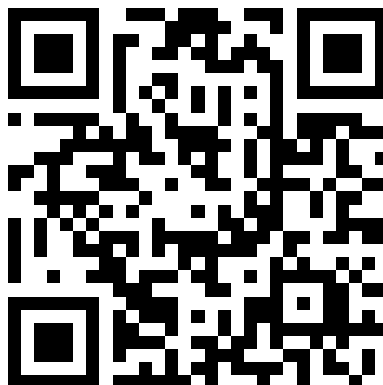
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

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Physician Assessment Form

Patient Name: _____ YH Reg. Number: _____

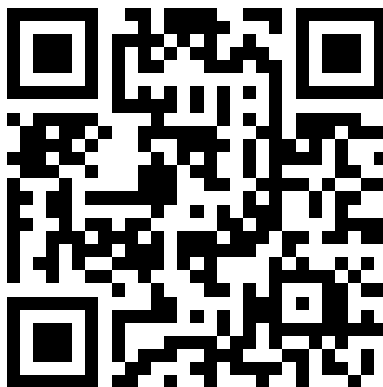
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

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Physician Assessment Form

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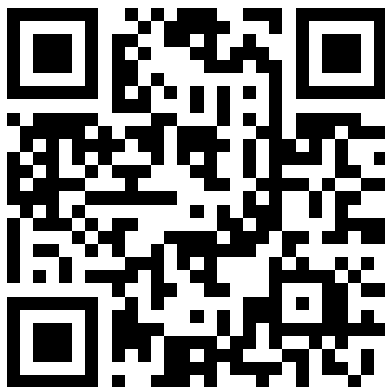
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Physician Assessment Form

Patient Name: _____ YH Reg. Number: _____

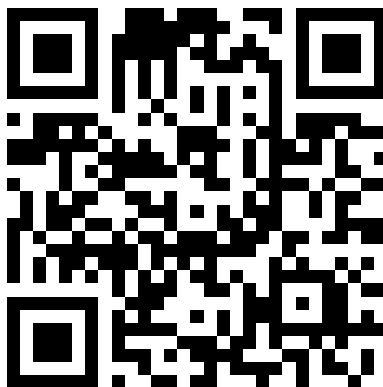
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

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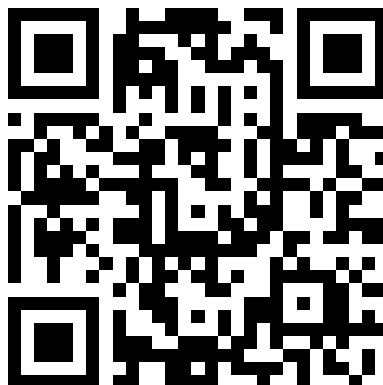
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

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Physician Assessment Form

Patient Name: _____ YH Reg. Number: _____

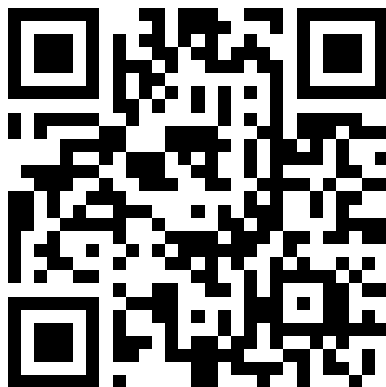
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

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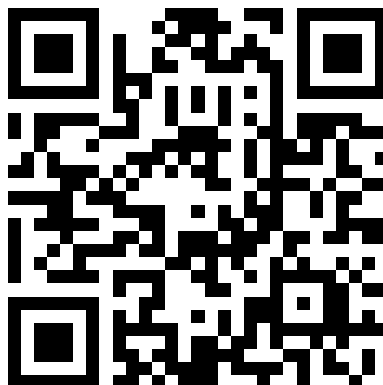
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

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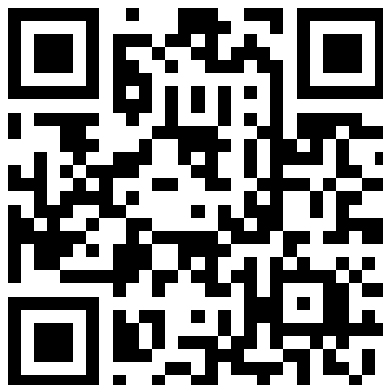
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

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Patient Name: _____ YH Reg. Number: _____

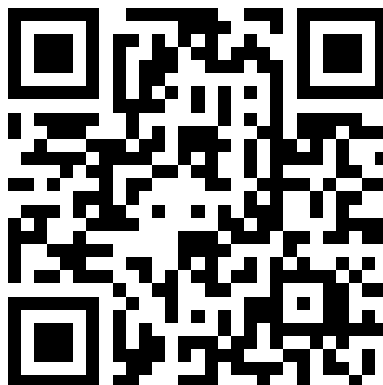
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

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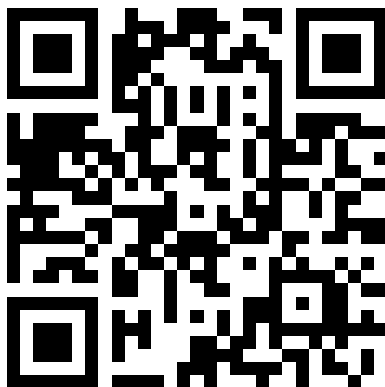
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

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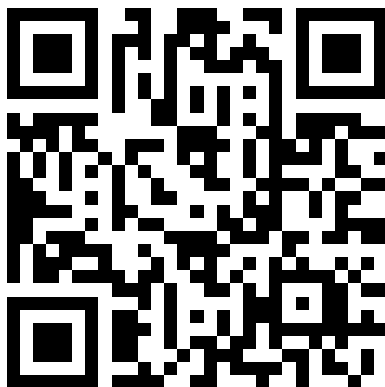
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

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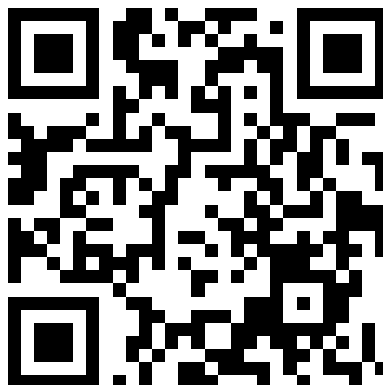
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

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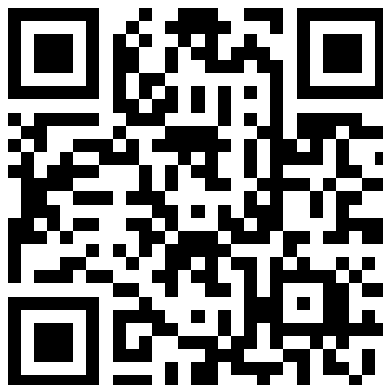
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Patient Name: _____ YH Reg. Number: _____

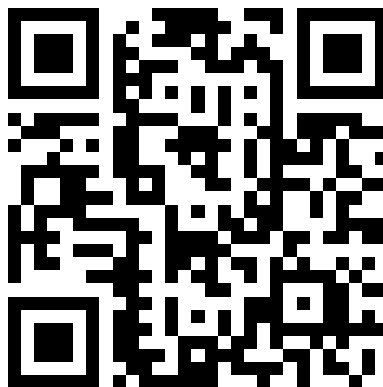
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

Respiratory Symptoms: Cough [], Wheezing [], Crackle [], Ronchi []

PFT Results(If Applicable): FVC: ____L, FEV1: ____L/sec, PEF: ____L/sec,

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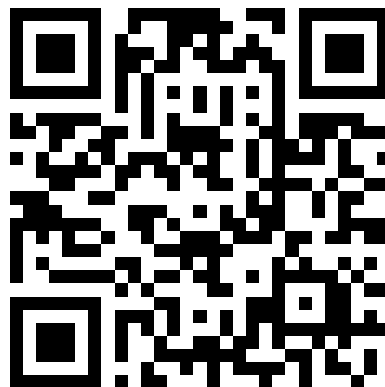
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

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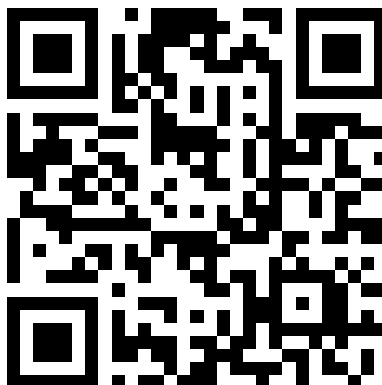
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

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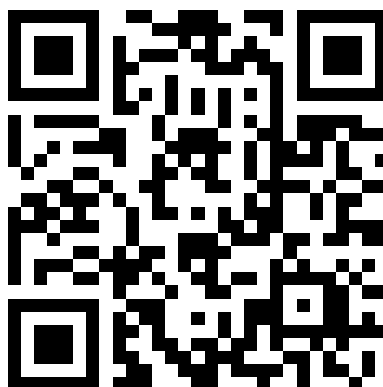
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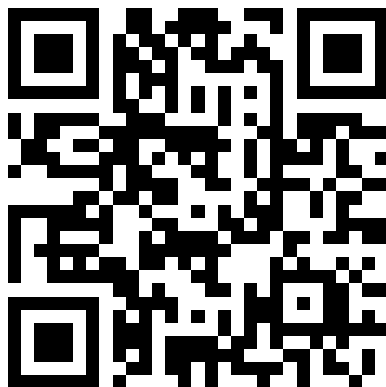
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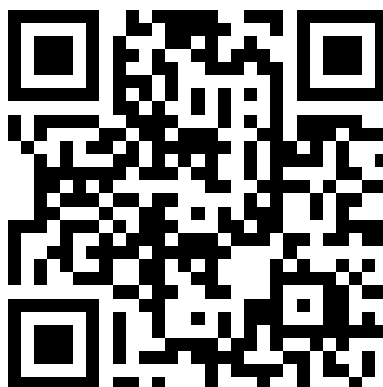
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

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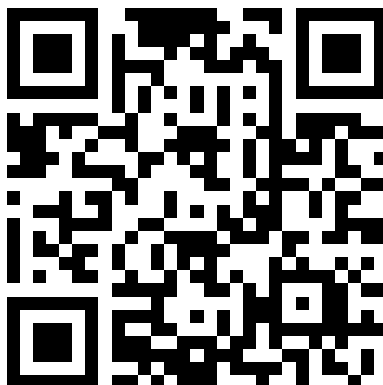
Date (DD/MM/YYYY): ____/____/____ Time (HH:MM AM/PM): ____:____

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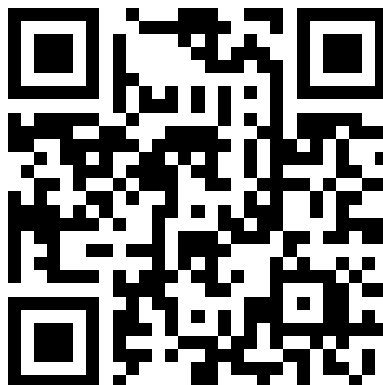
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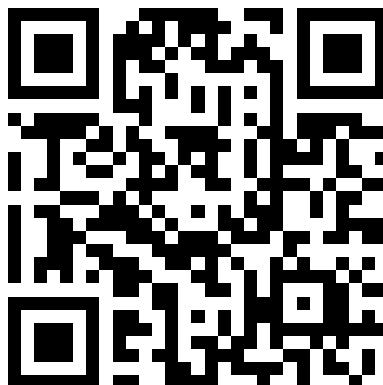
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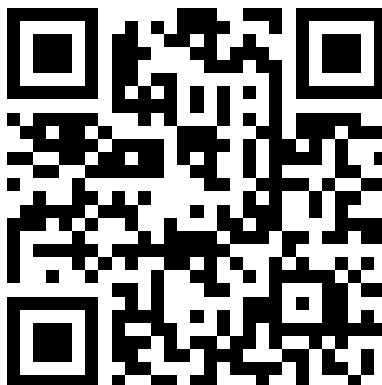
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