VIVAAN
ASSISTED LIVING

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Physical Evaluation Form

Name: _____

Date of Birth: _____ Phone No. _____

Address: _____

_____

Height: _____ Weight: _____

Blood Pressure: _____

Visual Acuity: _____

Auditory Acuity: _____

General Health: _____

_____

_____

Any other: _____

_____

_____

Signature of Physician: _____ Date: _____

Name of Physician: _____

Clinic or Hospital Name: _____

Address: _____