Vital Signs Log Sheet

Client name: _____ Clinician name: _____

Fill out every column in this sheet during each visit.

Visit Date	Visit Time	Time Recorded	Weight	Temperature (° F/°C)	Pulse (bpm)	Blood Pressure (Sys/Dia)	Respiration (bpm)	O2 Saturation (%)	Vital Signs	Initials / Signature	Notes