

Date of Visit:	Time of Visit:
Physician Name:	
Reason for Visit:	
Conditions / Problems: 1. 2. 3.	
Tests 1. 2. 3.	For problem #: 1. 2. 3.
Treatments 1. 2. 3.	For problem #: 1. 2. 3.
Medications 1. 2. 3.	For problem #: 1. 2. 3.
Immunizations 1. 2. 3.	Miscellaneous Remarks
Vital Signs	
Blood Pressure:	Pulse:
Temperature:	Respiration Rate:
Height:	Weight:
Follow Up Information	
Lab Tests:	
Lab Results:	
Other Tests:	

Next Appointment Date: _____

Phone Number for follow up: _____