This form is offered only to provide you with an idea of what information you may find helpful to record. It was created by a patient's spouse and is only a suggestion.

DOCTOR VISIT NOTES

DATE OF VISIT: _____

DOCTORS' NAME: _____ **PHONE #:** _____ **FAX #:** _____

BLOOD PRESSURE: _____ **WEIGHT:** _____**lbs.** **TEMP:** _____

REASON FOR VISIT: _____

SYMPTOMS: _____
_____

START DATE OF SYMPTOMS/FREQUENCY: _____
_____

CURRENT MEDICATIONS: (Dosage & Frequency) Including OVER THE COUNTER DRUGS, HERBS, VITAMINS.

1. _____	2. _____	3. _____
4. _____	5. _____	6. _____
7. _____	8. _____	9. _____
10. _____	11. _____	12. _____
13. _____	14. _____	15. _____
16. _____	17. _____	18. _____

ALLERGIES: _____
_____

DIAGNOSIS / OPINION: _____

DOCTOR RECOMMENDATIONS: _____
_____
_____

TREATMENT PERFORMED ON DAY OF VISIT: _____
_____

INJECTIONS: _____ **TESTS:** _____

ADDITIONAL MEDICAL SERVICES:

LAB WORK: _____
X-RAYS: _____
CT SCAN _____
MRI _____
OTHER: _____

NEW MEDICATIONS PRESCRIBED: _____ **DOSE:** _____
_____ **DOSE:** _____

NEW MEDICATIONS SIDE EFFECTS: _____
_____
_____
_____

REFERRALS TO SPECIALISTS: _____ **PHONE:** _____

_____

DATE TO CALL FOR TEST RESULTS: _____ **DATE OF FOLLOW-UP APPT.** _____

ADDITIONAL NOTES: _____

_____

_____

_____

_____