

# office visit

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

PRACTITIONER'S NAME \_\_\_\_\_ DATE OF VISIT \_\_\_\_\_

SPECIALTY \_\_\_\_\_

Purpose of visit, questions, symptoms, and concerns

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Office results of any tests and examination (height, weight, blood pressure, etc.)

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Doctor's conclusions and advice

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Action Plan: list tests to schedule, medication changes, treatment, diet advice, follow-up appointments

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- *Give your doctor a self-addressed, stamped envelope to send your test results to you.*