Primary Care Visit Form

Name:_____DOB: __/__/__ Date: __/__/__ MR#_____

Primary Care Doctor:_____Address:_____Phone:_____

Primary Care Doctor scheduled follow-up for:

_____

_____

Consumer Health Concern (Check all that apply)

- ☐ Prescriptions need to be refilled
- ☐ Attached forms need to be filled out
- ☐ New health questions/concerns
- ☐ Diet / weight
- ☐ Quitting smoking

concern:_____

_____

_____

Current Medical Conditions (list all):

_____

_____

_____

Current Medications

Medication	Dose	# of pills, times of day (i.e. 2 pills, 3x's a day, breakfast, lunch, dinner)	Taking as prescribed? Y/N	If not, why?	Start date	End date

Recent lab-work / testing:

☐ See attached / Pending test

_____

_____

Primary Care Doctor Recommendations today:

_____

_____

_____

_____

Medication Changes: ☐ No changes ☐YES see changes

Changes:_____

_____

_____

Next follow-up visit with Dr._____date:_____time:_____