



THIS FORM MUST BE COMPLETED AND BROUGHT TO EACH FOLLOW-UP VISIT

NAME: _____ D.O.B.: _____ Date: _____

HEIGHT: _____ WEIGHT: _____ Family Doctor: _____ Last Visit: _____

1. A FULL LIST OF ALL CURRENT MEDICATIONS INCLUDING VITAMINS AND OTHER OVER-THE-COUNTER MEDICATIONS OR SUPPLEMENTS MUST BE PROVIDED AT EACH VISIT.

- YOU MAY USE OUR MEDICATION LIST (KEEP A COPY FOR YOUR RECORDS)
• OR YOU MAY ATTACH A COPY OF YOUR MEDICATION LIST (HAVE US MAKE A COPY).

2. LIST ANY SIGNIFICANT MEDICAL EVENTS/TESTS DONE SINCE YOUR LAST VISIT, WITH DATES:

Four horizontal lines for listing medical events and tests.

3. OTHER MEDICAL PROBLEMS: STATUS/TREATMENT:

- 1. _____
2. _____
3. _____
4. _____
5. _____

4. LIST THE THREE (3) MOST IMPORTANT QUESTIONS YOU WANT ANSWERED TODAY:

- 1. _____
2. _____
3. _____

5. LIST ALL MEDICATIONS YOU NEED REFILLED AND ANY FORMS YOU NEED COMPLETED:

Four horizontal lines for listing medications and forms.

GET ALL YOUR PRESCRIPTION REFILLS TODAY. THERE IS A CHARGE FOR ALL PRESCRIPTION REFILLS BETWEEN OFFICE VISITS.