

**Human Resources Center, Inc.
PHYSICIAN VISIT FORM**

TO BE COMPLETED BY PROVIDER:

Name: _____ **Date of Birth** ___/___/___ **Date of Visit:** ___/___/___

Physician: _____ **Type of Physician:** _____

Presenting Problem: _____

***ALLERGIES*:** _____

Current Medications: _____

Other Physicians: _____

Provider Signature: _____

TO BE COMPLETED BY PHYSICIAN:

Height: _____ **Weight:** _____ **Blood Pressure:** _____

Diagnosis: _____

Treatment: _____

New Medications Prescribed: _____

Review of administration, side effects and contradictions was provided on new medication(s).

I have reviewed the medication(s) information provided and I am not aware of any drug interaction concerns.

RETURN VISIT REQUIRED: ___ YES ___ NO **If Yes, DATE:** _____

Physician's Signature