Dr. Eva Turner 10 East 704th St, Orangeburg NY 10962 845-359-5599

PATIENT:

DATE OF VISIT:_____ DOCTOR VISITED: Dr. Eva Turner

Progression of current condition, _____, is:_____
(condition)

_____

_____ (use back of page if necessary)

.....

New diagnosis/es given: NO / YES: _____

Prognosis: _____

.....

Rx DOSAGE CHANGE: No / YES: _____from _____to _____
(Rx name)

Rx DOSAGE CHANGE: No / YES: _____from _____to _____
(Rx name)

Rx DOSAGE CHANGE: No / YES: _____from _____to _____
(Rx name)

.....

NEW Rx NO / YES: For (condition/complaint) _____

_____ _____ REPLACES: _____
(NEW Rx name) (dosage) (Discontinue Rx name)

_____ _____ REPLACES: _____
(NEW Rx name) (dosage) (Discontinue Rx name)

_____ _____ REPLACES: _____
(NEW Rx name) (dosage) (Discontinue Rx name)

.....

Laboratory/Diagnostic TESTS ORDERED NO / YES: _____
(name of test)

Reason for test: _____

COPIES of results can either be copied for the patient or faxed to _____

THANK YOU.