Office Visit Checklist

Doctor's Name _____

Date of Visit _____

Current list of medications, including over-the-counter medications, prescription medications, and supplements:

Medication	Dose	Frequency	Notes

Please list any health concerns you may have below.

Has there been any changes in your physical or mental health since your last visit with this provider? If so, please describe them below.

Are there any new prescriptions, or changes in prescriptions after this visit?

Medication	Dose	Frequency	Instructions

Did your doctor refer you to any other provider during this visit? If so, leave instructions or details below.

Lab:	Specialist:	Imaging:

Next appointment date and time:

____ / ____ / ____ ____ : ____ AM / PM