OFFICE FOLLOWUP VISIT

Patient Name: xxxxxx
Date of Birth: mm/dd/yyy
Date of Visit: mm/dd/yyy

PRIMARY CARE PHYSICIAN: xxxxxxxxxx

SUBJECTIVE:

CURRENT MEDICATIONS:

PHYSICAL EXAMINATION:
VITAL SIGNS:
HEAD AND NECK:
LUNGS:
HEART:
ABDOMEN:
EXTREMITIES:
IMPRESSION:
.

RECOMMENDATIONS:
1 _____.
2. _____.

cc: xxxxxxx
xxxxxxxxx

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