MID HUDSON MEDICAL GROUP

Breast Center • Cardiology • Dermatology • ENT/Allergy/Audiology
Endocrinology • Family Practice • Gastroenterology • Hematology/Oncology
Imaging • Internal Medicine • Laboratory • Neurology • Nuclear Medicine
Obstetrics & Gynecology • Ophthalmology • Orthopedics • Pediatrics
Physical Therapy • Podiatry • Pulmonology • Rheumatology •Surgery
Urgent Care • Urology • Women's Imaging

PATIENT NAME _____ DATE OF BIRTH _____ CENTRICITY# _____

DOCTOR'S APPOINTMENT LOG

DATE: _____ TIME: _____

DOCTOR: _____

DID ANYONE ACCOMPANY YOU? _____

WHAT WAS YOUR REASON FOR VISIT? _____

WHO DID YOU SEE? _____

WHAT HAPPENED DURING YOUR VISIT? (I.E. EXAM LAB TEST, FLU SHOT)

_____

_____

DID YOU GET A REFERRAL TO A SPECIALIST OR FOR SOME TESTS/PROCEDURE? ☐ YES ☐ NO

TO WHOM? _____ FOR WHAT? _____

WHEN? _____ REFERRAL NUMBER: _____

DID YOU GET A NEW PRESCRIPTION? _____

WHAT IS IT FOR? _____ DOSAGE: _____

WHEN IS YOUR NEXT APPOINTMENT? _____

NOTES OR QUESTIONS FOR YOUR NEXT VISIT: