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### Return Visit Form

Patient name: \_\_\_\_\_

I am \_\_\_\_ better, \_\_\_\_ worse, \_\_\_\_ same/no change, since my last visit.

The reason you are seeing the provider today?

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Any changes in your medical condition(s) since you were last seen here? (Hospitalizations, new doctors/specialists, etc.)

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Top three questions you have for your provider:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Please list all current medications and supplements. Put a “✓” by new medications and an “x” by medications you have discontinued since your last visit.

#### Medications

#### Supplements

Medications		Supplements	

Use the backside if you need more room.