

Patient Information		Visit Information	
Name	DOB	Visit Date	Visit Time
John Doe	12/12/1980	01/15/2024	10:00 AM
Medical History		Vital Signs	
Hypertension Diabetes Mellitus Hyperlipidemia Asthma Chronic Kidney Disease	Allergies: Penicillin Shellfish	BP: 120/80 mmHg HR: 72 bpm RR: 18 breaths/min Temp: 37.5°C	Weight: 180 lbs Height: 5'10"
Physical Examination		Laboratory Results	
General: Well-appearing, no acute distress. HEENT: Normal. Lungs: Clear to auscultation. Heart: Regular rate and rhythm, no murmurs. Abdomen: Soft, no tenderness. Extremities: No edema.	Bloodwork: Hemoglobin: 14.5 g/dL Hematocrit: 45.0% Serum Creatinine: 1.2 mg/dL Fasting Glucose: 100 mg/dL	Urinalysis: Color: Yellow Clarity: Clear pH: 6.0 Protein: Negative Glucose: Negative	
Assessment		Plan	
Hypertension, well-controlled. Diabetes Mellitus, stable. Hyperlipidemia, stable.		Continue current medications. Follow up in 3 months. Lifestyle modifications: diet, exercise.	
Patient Education		Provider Signature	
Patient understands condition and plan. No further questions.		Dr. Jane Smith Primary Care Physician	