

TREATING PHYSICIAN STATEMENT

To be completed by the treating physician
(PLEASE USE BLOCK LETTERS)



1. PATIENT'S INFORMATION

Name	Last	First	M.I.
Date of birth	MM / DD / YY	Height <input type="checkbox"/> M <input type="checkbox"/> Ft	Weight <input type="checkbox"/> Kg <input type="checkbox"/> Lb

2. DETAILS ABOUT VISITS AND TESTS

Please provide complete details regarding all visits and diagnostic tests:

Date of last 5 visits	Details	
Date 1	Symptoms	
MM / DD / YY	Diagnosis	
Blood pressure	Treatment	
	Surgery	
Date 2	Symptoms	
MM / DD / YY	Diagnosis	
Blood pressure	Treatment	
	Surgery	
Date 3	Symptoms	
MM / DD / YY	Diagnosis	
Blood pressure	Treatment	
	Surgery	
Date 4	Symptoms	
MM / DD / YY	Diagnosis	
Blood pressure	Treatment	
	Surgery	
Date 5	Symptoms	
MM / DD / YY	Diagnosis	
Blood pressure	Treatment	
	Surgery	

Please provide any other diagnosis, symptoms, complications, or relevant factors regarding this patient that were not previously mentioned. Please detail evolution, treatment, and current status.

Please provide results of the following tests:									
Details of EKG results performed within the last 12 months (PLEASE INCLUDE EKG STRIP).									
Date									
MM / DD / YY									
Details of chest X-rays results performed within the last 12 months (PLEASE INCLUDE RADIOLOGY REPORT).									
Date									
MM / DD / YY									
Date		Values of blood test results performed within the last 6 months							
MM / DD / YY		Hematocrit		Hemoglobin		WBC		Platelets	
		Cholesterol		HDL		LDL		Triglycerides	
Red blood cells		Creatinine		Glucose		Glyco hemoglobin		PSA	
Please provide results of the following tests performed within the last 12 months:									
Details of tissue examination results: biopsies or surgeries (PLEASE INCLUDE REPORT).									
Date									
MM / DD / YY									
For women, details of PAP smear results (PLEASE INCLUDE REPORT).									
Date									
MM / DD / YY									
For women, details of mammography results (PLEASE INCLUDE RADIOLOGY REPORT).									
Date									
MM / DD / YY									
Prognosis		<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Reserved							
Has any other exam not described before been requested or performed within the last five years (for example, CT scan, MRI, echocardiogram, stress test, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide details.									
Date		Name of exam			Results				
MM / DD / YY									
MM / DD / YY									
MM / DD / YY									
Has the patient consulted another physician? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide details.									
Date		Name of physician				Telephone			
MM / DD / YY									
Reason for the visit									
3. TREATING PHYSICIAN'S INFORMATION									
Name									
Address									
Telephone		Fax		Email					
Date		Signature							
MM / DD / YY									