HEALTH VISIT REPORT

Client Name: ____________________________________ Date of Birth: ___________________

Name of Provider: _______________________________ Date of Visit: ___________________

Facility Address: ____

Facility Phone Number: __________________________ Fax Number: ___________________

I. Please check the type of visit:

- ○ INITIAL HEALTH SCREEN
- ○ COMPREHENSIVE HEALTH ASSESSMENT
- ○ DENTAL EXAMINATION
- ○ EYE EXAMINATION
- ○ SICK VISIT
- ○ EMERGENCY
- ○ THERAPY APPOINTMENT
- ○ PSYCHIATRIC EVALUATION
- ○ MEDICATION EVALUATION
- ○ OTHER:____

II. Visit Information

1. ASSESSMENT / DIAGNOSIS:____

____

____

____

____

2. LIST IMMUNIZATIONS:____

____

3. FOLLOW UP NEEDED? (Please explain and indicate if condition requires additional visits, noting frequency and expected completion dates.):

____

____

____

____

____________________________________ ____________________________

Provider Signature Date

6511 Princess Garden Parkway ♦Lanham, MD 20706 ♦ TELEPHONE (301) 552-5425 ♦ FAX (301) 552-5427