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 / YYYY	Height ☐ M ☐ Ft		Weight ☐ Kg ☐ 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 / YYYY	Diagnosis	
Blood pressure	Treatment	
	Surgery	
Date 2	Symptoms	
MM / DD / YYYY	Diagnosis	
Blood pressure	Treatment	
	Surgery	
Date 3	Symptoms	
MM / DD / YYYY	Diagnosis	
Blood pressure	Treatment	
	Surgery	
Date 4	Symptoms	
MM / DD / YYYY	Diagnosis	
Blood pressure	Treatment	
	Surgery	
Date 5	Symptoms	
MM / DD / YYYY	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 / YYYY								
Details of chest X-rays results performed within the last 12 months (PLEASE INCLUDE RADIOLOGY REPORT).								
Date								
MM / DD / YYYY								
Date	Values of blood test results performed within the last 6 months							
MM / DD / YYYY	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 / YYYY								
For women, details of PAP smear results (PLEASE INCLUDE REPORT).								
Date								
MM / DD / YYYY								
For women, details of mammography results (PLEASE INCLUDE RADIOLOGY REPORT).								
Date								
MM / DD / YYYY								
Prognosis	☐ Excellent ☐ Good ☐ 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.)? ☐ Yes ☐ No If "Yes", please provide details.								
Date	Name of exam	Results						
MM / DD / YYYY								
MM / DD / YYYY								
MM / DD / YYYY								
Has the patient consulted another physician? ☐ Yes ☐ No If "Yes", please provide details.								
Date	Name of physician	Telephone						
MM / DD / YYYY								
Reason for the visit								

3. TREATING PHYSICIAN'S INFORMATION

Name					
Address					
Telephone		Fax		Email	
Date	MM / DD / YYYY	Signature			

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