

PRIMARY CARE PROVIDER PATIENT SUMMARY

Date:

Physician Information:

[Empty text box for Physician Information]

Patient Information:

[Empty text box for Patient Information]

Ongoing Concerns and Medical History:

[Empty text box for Ongoing Concerns and Medical History]

Last Visit information:

Last visit date:

Last BP: ()

Last weight: kg ()

Last height: cm ()

Last BMI: ()

Relevant Lab Results:

Last Hgb: ()

Last A1c: ()

Last eGFR: ()

Current Medications:

[Empty text box for Current Medications]

Other Medications:

[Empty text box for Other Medications]

**Allergies:
(note
reaction)**

[Empty text box for Allergies]