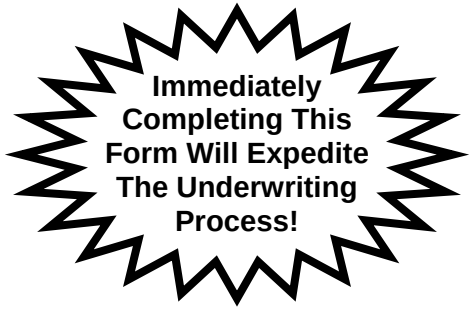
_____

Advisor's Name Here



Physician/Treatment/Medication Data

_____

Your Name

Your Doctor's Name	Doctor's Address	Doctor's Phone Number	Date & Reason for Last Visit	Treatment / Medication*	Follow Up Plans

* Please include any special testing, the doctor/facility that performed the test and the results.

Please list all medications you are taking that are not mentioned above and provide the name of the doctor that prescribed the medication.

1. _____
2. _____