Encounter Form

Patient Information:

Name: Jane Doe Date of Birth: 01/15/1985

Date of Visit: 08/10/2023 Patient ID: 123456789

Contact Number: (555) 123-4567

Medical Departments:

- ☐ **General Medicine**
- ☑ Initial Consultation
- ☐ Follow-Up: _____
- ☐ Emergency Visit
- ☑ Regular Checkup
- ☑ Immunization
- ☐ Surgery Consultation
- ☐ **Dental**
- ☐ Oral Exam/Cleaning
- ☐ Dental X-Ray
- ☐ Cavity Filling
- ☐ Orthodontia
- ☐ Surgery: _____
- ☐ **Behavioral Health**
- ☐ Initial Psychological Evaluation
- ☐ Therapy Session
- ☐ Medication Consultation
- ☐ Crisis Intervention
- ☐ **Vision**
- ☑ Initial Eye Exam
- ☐ Glasses Prescription
- ☐ Contact Lens Fitting
- ☐ Follow-Up: _____

☐ **Hearing**

☐ Hearing Test

☐ Hearing Aid Fitting

☐ Follow-Up: _____

Diagnosis/Conditions (Include medical, mental health, developmental, learning, etc.):

Hypertension
Mild astigmatism in the right eye

Procedures Conducted & Results:

Blood pressure measurement: 145/90
Eye exam: Mild astigmatism detected

Immunizations Administered:

Annual flu shot

Known Allergies:

Penicillin

Prescription(s) Issued:

Lisinopril for hypertension
Prescription eyeglasses for astigmatism

Follow-up or Referral Required:

☑ Yes (Provide details below)

☐ No

Follow-up in 2 weeks for a vision re-check and blood pressure evaluation.

Additional Notes (Medical or Social):

Patient advised to reduce salt intake and monitor blood pressure at home.

Provider Details:

Signature: Dr. John Smith

Printed Name: Dr. John Smith

Facility: Cornelia Street Medical Center

Contact Number: (555) 987-6543

ADMINISTRATIVE USE ONLY:

Date Processed: 08/11/2023

Processed By: Lisa M.

Note: Retain a copy of this Encounter Form in the Medical Section of the patient's record.