Personalized Treatment Plan

JOHNS HOPKINS HEALTH PLANS

Patient Name: _____ **Date of visit:** _____

1. **VISIT SUMMARY/DIAGNOSES**

   _____

2. **YOUR VITAL SIGNS**
   Blood pressure:_____ **Temperature:** _____

   BMI: _____ **Weight:** _____

3. **YOUR TREATMENT PLAN**

   _____

4. **YOUR MEDICINES**
   New medicines

   _____

   Current medicines

   _____

   Current medicines with new doses/instructions

   _____

   Medicines you NO LONGER take

   _____

5. **YOUR REFERRAL INFORMATION**

   _____

6. **YOUR NEXT APPOINTMENT IS ON** _____ **AT** _____**a.m./p.m.**

7. **BEFORE YOUR NEXT APPOINTMENT**

   _____

I understand that I am responsible to take this form to my assigned PCP during my next office visit.

Patient signature: _____ **Date:** _____

Physician signature: _____ **Date:** _____