PHYSICIAN INFO AND TREATMENT PROTOCOL

Physician		**Phone number/ fax/ email**	
Clinic		**Address**	
Date of visit	Notes		
Physician		**Phone number/ fax/ email**	
Clinic		**Address**	
Date of visit	Notes		
Physician		**Phone number/ fax/ email**	
Clinic		**Address**	
Date of visit	Notes		

Medication

Date started	Date to finish	Generic / Other Name, Brand	Dose	# of times per day	With/ away from food	Route of administration	Refrigeration	Possible side effects	Special notes

Supplements

Date started	Date to finish	Generic / Other Name, Brand	Dose	# of times per day	With/ away from food	Route of administration	Refrigeration	Possible side effects	Special notes

Botanical medicine

Date started	Date to finish	Generic / Other Name, Brand	Dose	# of times per day	With/ away from food	Route of administration	Refrigeration	Possible side effects	Special notes

Other Treatments

Date started	Date to finish	Generic / Other Name, Brand	Dose	# of times per day	With/ away from food	Route of administration	Refrigeration	Possible side effects	Special notes