AFFINITY™
PHYSICIAN NETWORK

Office Visit Progress Note

NAME: _____

DOB: _____/_____/_____(mm/dd/year)

DATE: _____

C/C: The patient relates having problems with the following (check all that apply & provide a brief explanation):

- ☐ Weight gain: _____
- ☐ Libido: _____
- ☐ Fatigue: _____
- ☐ Decreased motivation: _____
- ☐ Sleep issues: _____
- ☐ Trouble focusing: _____
- ☐ Stress/Anxiety: _____
- ☐ Muscle loss/joint pain: _____
- ☐ Other: _____

Females Only:

- ☐ Menstrual abnormalities: _____
- ☐ Hot flashes: _____
- ☐ Painful intercourse: _____
- ☐ Night sweats: _____
- ☐ Vaginal dryness: _____

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Office Visit Progress Note (continued)

Family History:

_____

_____

_____

Medical History:

_____

_____

_____

Medications:

_____

_____

_____

Practiconer Signature:

_____

Date:

_____