



DICKSON DAVIS LAW FIRM

Medical Visits Log Form

Name: _____ Beginning Date: ___/___/___

Medical Treatment		Medical Facility (or Professional)	Describe Treatment	Diagnosis
From	To			
___/___/___	___/___/___	_____	_____	_____
___/___/___	___/___/___	_____	_____	_____
___/___/___	___/___/___	_____	_____	_____
___/___/___	___/___/___	_____	_____	_____
___/___/___	___/___/___	_____	_____	_____
___/___/___	___/___/___	_____	_____	_____
___/___/___	___/___/___	_____	_____	_____
___/___/___	___/___/___	_____	_____	_____
___/___/___	___/___/___	_____	_____	_____
___/___/___	___/___/___	_____	_____	_____
___/___/___	___/___/___	_____	_____	_____
___/___/___	___/___/___	_____	_____	_____
___/___/___	___/___/___	_____	_____	_____