Before My Doctor’s Visit

Date of visit _______________________

Doctor’s name ______________________
Address __________________________
_________________________________
_________________________________
Phone  ___________________________

Reason for this visit  _________________
_________________________________

Symptoms/medical problem you are having
_________________________________
_________________________________
_________________________________

How long have you had this problem or symptoms? ________________________
_________________________________

Questions you want to ask the doctor about this problem or symptoms  ____________
_________________________________
_________________________________

List below all of the prescription and non-prescription (OTC) medicines you are now taking.

(Show this list to your doctor during your visit)

Prescription Medicines
_________________________________
_________________________________
_________________________________

Over-the-Counter (nonprescription) Medicines and Vitamins / Minerals, Dietary / Herbal Supplements
_________________________________
_________________________________
_________________________________

Questions to Ask About Prescription Medicines

(If my doctor prescribes medicine for me, here are some important questions to ask)

1. What is the name of the medicine and what is it for? ______________________
   q brand name or the  q generic name?

2. How and when do I take it—and for how long? ____________________________

3. What side effects should I expect, and what should I do about them? ________

4. Should I take this medicine on an q empty stomach or  q with food?
   Is it safe to drink alcohol with this medicine  q yes or  q no

5. If it’s a once-a-day dose, is it best to take it in the  q morning or  q evening?

6. What foods, drinks, or activities should I avoid while taking this medicine? _____

7. Will this medicine work safely with any other medicines I am taking?  q yes  q no

8. When should I expect the medicine to begin to work, and how will I know if it is working?

_________________________________

Are there any tests required with this medicine (for example, to check liver or kidney function)?

_________________________________

9. How should I store this medicine?

_________________________________

10. Is there any written information available about the medicine?
   q yes or  q no?
   Is it available in large print or a language other than English?  q yes or  q no?

_________________________________

After My Doctor’s Visit

Call your doctor immediately if you are having any problems with your treatment.

Call your doctor or pharmacist if you think you are having troubling side effects with any medicine prescribed or recommended for you.

Pharmacy _________________________
Phone ____________________________

Record the date and time for any scheduled blood tests, x-rays, or other medical tests ordered by your doctor.
Test  _____________________________
Phone ____________________________
Testing facility ______________________

Record the date and time of your next doctor’s visit  ______________________

Keep up to date
Use 1 sheet for each doctor you visit