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 you 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? ______________________

   □ brand name or the □ 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 □

   empty stomach or □ with food?

   Is it safe to drink alcohol with this medicine

   □ yes or □ no

5. If it's a once-a-day dose, is it best to take

   it in the □ morning or □ 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? □ yes □ 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?

    □ yes or □ no?

    Is it available in large print or a language

    other than English? □ yes or □ 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

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