MY NOTES FOR MY HEALTH CARE PROVIDER

Below is a fillable form for patients and caregivers to use when preparing for, during, and after a visit with their health care provider.

BEFORE THE VISIT

RECORD YOUR SYMPTOMS

Symptom	How long has it occurred?	How often does it occur?	When does it occur?	Where does it occur?	What improves or worsens it?	Any other information

BE YOUR OWN HEALTH ADVOCATE

My concerns: _____

_____

_____

What I want to discuss: _____

_____

_____

Goals of the appointment: _____

_____

_____

Specific questions: _____

_____

_____

WRITE DOWN YOUR MEDICAL HISTORY

(SURGERIES, MAJOR ILLNESSES, PROCEDURES)

_____

_____

_____

_____

WRITE DOWN ANY RELEVANT FAMILY MEDICAL HISTORY

(DISEASES OR MAJOR MEDICAL EVENTS)

Name of Family Member/Relationship Medical History

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

MAKE A LIST OF ALL THE DRUGS & SUPPLEMENTS THAT YOU TAKE

Drug, supplement, or vitamin	Purpose	Dosage	Frequency	Duration

MAKE A LIST OF ALL YOUR HEALTH CARE PROVIDERS & PREVIOUS APPOINTMENTS

Name of Provider	Reasons for Visit	Results	Date	Contact Info

UNDERSTAND IMPORTANT FINANCIAL INFORMATION

DURING THE VISIT

TAKE NOTES DURING THE APPOINTMENT

Diagnosis:

_____

_____

_____

Treatment Options:

_____

_____

_____

Testing:

_____

_____

_____

Next Steps:

_____

_____

Any Other Notes:

_____

_____

_____

_____

Follow-up Care:

_____

_____

QUESTIONS TO ASK REGARDING THE DIAGNOSIS

Is testing required?

_____

_____

_____

_____

Is testing typically covered by insurance?

_____

_____

_____

_____

What does the diagnosis mean? How serious is the diagnosis?
What does it mean for today, short-term, and long-term?

_____

_____

_____

_____

What caused the diagnosis?

_____

_____

_____

_____

What risk factors are associated with this disease or condition?

_____

_____

_____

_____

QUESTIONS TO ASK REGARDING TREATMENT

What are the current treatments options?

_____

_____

_____

What are the instructions for taking the treatment? How frequently and for how long do I need to take this treatment? What side effects should I look out for?

_____

_____

_____

How will I know if the treatment is effective?

_____

_____

_____

What are common side-effects?

_____

_____

_____

What is the cost of this treatment?

_____

_____

_____

What would happen if I delayed treatment?

_____

_____

_____

QUESTIONS TO ASK REGARDING FOLLOW-UP CARE:

Do I need to see a specialist?

_____

_____

_____

Do I need any follow-up care/appointment?

_____

_____

_____

If symptoms don't improve, worsen, or return, when should I come back?

_____

_____

_____

Are there any symptoms I should watch for?

_____

_____

_____

How might lifestyle changes, nutrition, or other environmental factors help or harm my condition?

_____

_____

_____

If treatments aren't working, are there clinical trial options?

_____

_____

_____

AFTER THE VISIT

KEEP TRACK OF YOUR SYMPTOMS & HOW YOU FEEL ON YOUR MEDICATION

Date	Symptoms	Date	Symptoms

General Notes:

KEEP TRACK OF YOUR ADHERENCE TO THE TREATMENT PLAN

Make note if you are taking your medication consistently, and if you aren't able to take it consistently, look to understand why. For example, do you need to set an alarm, need transportation help getting to the office for an infusion, or need financial assistance to afford the copay cost-sharing for the medication?

Date	Reason

General Notes:

MY CONCERNS WITH MY CURRENT TREATMENT: