

PREPARING FOR YOUR NEXT HEALTH VISIT – Generic Form

Introduction

When you and your health care team such as your doctors, nurse, and pharmacist are working together, your health can only improve. Plan your next visit. Know what your goals are, or at least the questions that you want answered. Bring this form to your next health visit and discuss its role in the management plan of your health care team.

Issues to discuss with your doctor

Your concerns are important to your doctor! Are you experiencing any side effects? Do you need a prescription renewal or do you want your blood work? Is there anything that you don't understand about your care?

Today's date: _____ Birthday: _____ E-mail address: _____
First name: _____ Last name: _____
Address: _____ City: _____ Postal Code: _____
Telephone # home: _____ Work _____ Best time to call: _____

A – Medications:

Always bring a list of all your medications including doses to every physician visit (use one of the blue "medication profile" cards); use the list below as a guide. Better yet, bring in all your medications, complete page 12 of the High Road to Health Passport, or attach a medication list from your pharmacy.

| Medication | Dosage | Reason for taking |
|------------|--------|-------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

How often do you forget to take your medication?

___ Never ___ rarely ___ sometimes ___ frequently

If you are having any side effects or you are not taking your pills properly do not adjust them on your own but discuss them with your physician or pharmacist:

Allergies or Side Effects: _____

B – Questions I Have for My Physician:

Medical issues are becoming more and more complex. Most physician visits are brief but should include what you would like to discuss. While not all issues may be addressed, having a list and setting priorities are important steps. Primary or main question: _____

Other questions that I would like addressed:

C – Current Medical issues and medical history (Please check all that apply):

- | | | |
|---|---|---|
| <input type="checkbox"/> dizzy or fainting spells | <input type="checkbox"/> loss of appetite | <input type="checkbox"/> cancer |
| <input type="checkbox"/> failing vision | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> leg pain – when walking | <input type="checkbox"/> heartburn | <input type="checkbox"/> thyroid disease |
| <input type="checkbox"/> bronchitis/chronic cough | <input type="checkbox"/> peptic ulcer | <input type="checkbox"/> seizures |
| <input type="checkbox"/> asthma/wheezing | <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> stroke |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> gallbladder trouble | <input type="checkbox"/> headaches |
| <input type="checkbox"/> chest pain with activity | <input type="checkbox"/> worsening chest pain | <input type="checkbox"/> jaundice/hepatitis |
| <input type="checkbox"/> arthritis/rheumatism | <input type="checkbox"/> depression/anxiety | <input type="checkbox"/> blood transfusions |
| <input type="checkbox"/> diarrhea/constipation | <input type="checkbox"/> back pain | <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> swollen ankles | <input type="checkbox"/> osteoporosis | <input type="checkbox"/> sexual concerns |
| <input type="checkbox"/> palpitations | <input type="checkbox"/> bloody or tarry stools | <input type="checkbox"/> gout |
| <input type="checkbox"/> blood in urine | <input type="checkbox"/> sleep difficulty | <input type="checkbox"/> suicidal |
| <input type="checkbox"/> muscle soreness/weakness | <input type="checkbox"/> anemia/bruise easily | <input type="checkbox"/> weight loss/gain |

Female patients – please complete

Menstrual flow: regular irregular flushing/menopausal symptoms

Date of last period _____

D – Prevention:

The best way to treat a disease is to prevent it from happening. BP:

What is your cholesterol? _____ Minutes of activity per week: _____

What is your blood sugar? _____ Are you watching your diet: _____

What is your blood pressure? _____ Weight: _____

Are you a smoker? _____ Cigarettes per day: _____ Quit date: _____

Are there stresses in your life or are you depressed: _____

Conclusion

Do not take your health for granted. Prepare for your next physician visit. Keep a copy for your records and leave one for your physician’s chart. Do not be afraid to say to your doctor that you do not understand certain points of your health. Do not forget to use the ER for true emergencies like chest pain coming from your heart unrelieved by 3 sprays of Nitro taken 5 mins apart that lasts greater than 15 mins. Call 911!