

Pre - Appointment Preparation Worksheet

Medications I am **currently** taking:

Medication	Dosage (how much/how often)

Medications I have **stopped or changed** since my last appointment:

Medication	Old Dosage	New Dosage	Reason for stopping/ changing

Test results **I need**/Tests **had done** (by other doctors) since my last appointment:

Test	Date Test was done

Other Health Care Providers I am currently seeing:

Doctor's Name	What I am seeing him/her for

PATIENT NAME _____ DOCTOR NAME _____
 DATE _____

Main reason for my visit today: _____

Symptom/ Problem/ Concern	When does it hap- pen? (ie. walking, morning, meals)	How often does it occur?	When did it start?	How severe/strong is it? (1=mild, 10=extremely strong)	What makes it better or worse?

Other concerns I have:

Symptom/ Problem/ Concern	When does it hap- pen?	How often does it occur?	When did it start?	How severe/strong is it?	What makes it better or worse?

Other concerns/issues to discuss:

Questions for the doctor:
