

# TALKING WITH MY DOCTOR

Doctor's name \_\_\_\_\_

Date of last visit \_\_\_\_\_ Date of next visit \_\_\_\_\_

Reason for visit \_\_\_\_\_

What has changed since my last visit \_\_\_\_\_

\_\_\_\_\_

Medicine I am currently taking	MEDICINE NAME	STRENGTH	HOW OFTEN I TAKE IT

- |   |  |
|---|--|
| Things to talk about with my doctor today                       | <input type="checkbox"/> Any symptoms  |
|   | <input type="checkbox"/> Any side effects                                    |
|   | <input type="checkbox"/> How my medicine is working                          |
|   | <input type="checkbox"/> How I am feeling                                    |
|   | <input type="checkbox"/> I wasn't able to get my medicine                    |
|   | <input type="checkbox"/> I stopped taking my medicine                        |
|   | <input type="checkbox"/> Another doctor changed my medicine                  |
|   | <input type="checkbox"/> I would like more information about my medicine     |
|   | <input type="checkbox"/> I need a new prescription for my medicine           |
|   | <input type="checkbox"/> Do I need any blood work?                           |
|   | <input type="checkbox"/> Last time my weight and blood pressure were checked |
| <input type="checkbox"/> Ideas I have about managing my illness |  |