

My Healthcare Provider Visits— How Can I Get Ready?

Prepare before you go to your provider’s office. Ask yourself these questions and discuss with your provider during your visit.

Since my last visit on:	/ /	/ /	/ /	/ /
Have my symptoms been any better or worse?	Y N <input type="checkbox"/> <input type="checkbox"/>	Y N <input type="checkbox"/> <input type="checkbox"/>	Y N <input type="checkbox"/> <input type="checkbox"/>	Y N <input type="checkbox"/> <input type="checkbox"/>
Have I taken my medicines as directed by my provider?	Y N <input type="checkbox"/> <input type="checkbox"/>	Y N <input type="checkbox"/> <input type="checkbox"/>	Y N <input type="checkbox"/> <input type="checkbox"/>	Y N <input type="checkbox"/> <input type="checkbox"/>
Have I started or stopped taking any medicines, supplements or vitamins?	Y N <input type="checkbox"/> <input type="checkbox"/>	Y N <input type="checkbox"/> <input type="checkbox"/>	Y N <input type="checkbox"/> <input type="checkbox"/>	Y N <input type="checkbox"/> <input type="checkbox"/>
Have my medicines caused any side effects?	Y N <input type="checkbox"/> <input type="checkbox"/>	Y N <input type="checkbox"/> <input type="checkbox"/>	Y N <input type="checkbox"/> <input type="checkbox"/>	Y N <input type="checkbox"/> <input type="checkbox"/>
Has my mood been better or worse since my last visit?	Y N <input type="checkbox"/> <input type="checkbox"/>	Y N <input type="checkbox"/> <input type="checkbox"/>	Y N <input type="checkbox"/> <input type="checkbox"/>	Y N <input type="checkbox"/> <input type="checkbox"/>
Have I had additional stress or life changes (good or bad) since my last visit?	Y N <input type="checkbox"/> <input type="checkbox"/>	Y N <input type="checkbox"/> <input type="checkbox"/>	Y N <input type="checkbox"/> <input type="checkbox"/>	Y N <input type="checkbox"/> <input type="checkbox"/>
Have I made progress toward my health goals?	Y N <input type="checkbox"/> <input type="checkbox"/>	Y N <input type="checkbox"/> <input type="checkbox"/>	Y N <input type="checkbox"/> <input type="checkbox"/>	Y N <input type="checkbox"/> <input type="checkbox"/>
Have I had any problems paying for my medicines?	Y N <input type="checkbox"/> <input type="checkbox"/>	Y N <input type="checkbox"/> <input type="checkbox"/>	Y N <input type="checkbox"/> <input type="checkbox"/>	Y N <input type="checkbox"/> <input type="checkbox"/>
	Y N <input type="checkbox"/> <input type="checkbox"/>	Y N <input type="checkbox"/> <input type="checkbox"/>	Y N <input type="checkbox"/> <input type="checkbox"/>	Y N <input type="checkbox"/> <input type="checkbox"/>
	Y N <input type="checkbox"/> <input type="checkbox"/>	Y N <input type="checkbox"/> <input type="checkbox"/>	Y N <input type="checkbox"/> <input type="checkbox"/>	Y N <input type="checkbox"/> <input type="checkbox"/>

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