Appointment Checklist

- Bring your list of questions
- Bring a description list of symptoms
- Organize a driver, if you are not allowed to drive home
- Pack a drink
- Pack a snack
- Pack a book or earbuds to listen to a podcast
- Ask if you can record the appointment
- Take someone into the appointment with you
- Bring printed test results to a new specialist or consultant
- Bring your medical history/medication list

From the book!

'Help the Doctor Help You'

Symptom Description List

- Is the pain sharp, dull, radiating, throbbing, burning, debilitating?
- Is the problem itchy, red, hot, sore to touch?
- ·Is it swollen? Can you move it?
- Is the pain constant or does it ebb and flow?
- Does anything make it feel better? If so, what?
- Does anything make it feel worse? If so, what?
- How long have you had the pain or symptoms?
- Did your symptoms come on fast or gradually?
- In general, are they getting worse?
- How many times a day do you have the symptom(s)?
- How would you rate the symptom on a scale of 1 – 10? (10 being YOUR worst ever.)
- Was there an incident or accident that caused your pain? (A fall, twist, etc.)
- Does your problem affect your sleep?
- Are you struggling emotionally?

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List of Helpful Questions

1) When should I expect my test appointment to come through?

2) When can I expect the test results?

3) Should I make a follow-up appointment?

4) Does it matter what time of day I take the medication?

5) How soon would you expect the medication to make a difference?

6) How soon should I make another appointment if I don't improve?

7) Are there alternative therapies you could recommend? (Physio, massage, etc.)

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Medical History Form

Name_____ Date:_____

Medication List

Medication_____
Dose (MG/mcg)_____AM____ PM____Bedtime____

Medication_____
Dose (MG/mcg)_____AM____ PM____Bedtime____

Medication_____
Dose (MG/mcg)_____AM____ PM____Bedtime____

Medication_____
Dose (MG/mcg)_____AM____ PM____Bedtime____

Medication_____
Dose (MG/mcg)_____AM____ PM____Bedtime____

Medication_____
Dose (MG/mcg)_____AM____ PM____Bedtime____

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Medical History Form

Surgical Procedures

Procedure	Year

Medical Professionals

Name	Specialty	Phone

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