



# Getting Ready for Your Next Office Visit

## Appointment Information

Provider Name: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

## Other Healthcare Providers I Am Seeing

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Reason to see this healthcare provider: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Reason to see this healthcare provider: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Reason to see this healthcare provider: \_\_\_\_\_

## Prescribed and Over-the-Counter Medicines and Supplements

Name of Drug/Supplement	Dose	Frequency	Prescribed/Recommended by
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

Name of My Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

## Symptoms I Have Been Experiencing

Coughing	Feeling nervous
Chest tightness	Rapid heartbeat
Wheezing	Head/nose stopped up
Unable to exercise	Restlessness
Feeling tired	Fever
Need to clear throat repeatedly	Stroking chin or throat
Dry mouth	Increased use of quick-relief inhaler
Waking up at night	Other:

How frequently these symptoms occur: \_\_\_\_\_

When the symptoms begin: \_\_\_\_\_

Things I do to relieve these symptoms: \_\_\_\_\_

## Additional Concerns and Questions

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## Next Steps

Notes from my healthcare provider: \_\_\_\_\_

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Tests to schedule: \_\_\_\_\_

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Next appointment (Day/Time): \_\_\_\_\_