



Before Your Doctor's Appointment

Prepare to get the most out of your visit!

Use this checklist to mark the topics most important to you right now. Fill it out ahead of time. Then, bring this sheet—plus a list of your prescription and over-the-counter medications—to the appointment with you.

WHAT I WANT TO TALK ABOUT:

- | | |
|-----------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> New or ongoing symptoms | <input type="checkbox"/> Preventive screenings
(colonoscopy/other cancer screenings, bone density, diabetes) |
| <input type="checkbox"/> Mental health concerns
(e.g., stress, anxiety, depression) | <input type="checkbox"/> Vaccinations
(e.g., flu, shingles, COVID-19) |
| <input type="checkbox"/> Any falls or balance issues | <input type="checkbox"/> Recent medication changes |
| <input type="checkbox"/> Incontinence/bladder control | <input type="checkbox"/> Concerns about medication side effects |
| <input type="checkbox"/> Hearing trouble | <input type="checkbox"/> Prescription refills needed |
| <input type="checkbox"/> Memory concerns | <input type="checkbox"/> Other concerns |
| <input type="checkbox"/> Sleep problems or fatigue | |
| <input type="checkbox"/> Weight changes | |

Add extra details here about the checked-off items above. How are you feeling? What are your specific concerns? Jot down anything you don't want to forget.

NOTES:

At Your Doctor's Appointment

Make an action plan!

Work with your primary care provider to fill in these details. Don't leave without understanding your care plan and what you need to do next.

TESTS OR SCREENINGS I NEED:

Test name: _____ Test name: _____

Who will schedule it (me, my provider or another office): _____ Who will schedule it (me, my provider or another office): _____

If I need to schedule it, here's the number to call: _____ If I need to schedule it, here's the number to call: _____

CHANGES TO MY MEDICATIONS (new prescriptions or dosage adjustments):

Medication name: _____ Medication name: _____

New dose: _____ New dose: _____

When to take it: _____ When to take it: _____

OTHER TAKEAWAYS (such as diet, exercise, sleep or other recommendations):

UPCOMING APPOINTMENTS:

Provider: _____ Provider: _____

Reason: _____ Reason: _____



STOP: Do you still have questions?
Ask them now before you leave the doctor's office!