Before My Doctor’s Visit

Date of visit _______________________

Doctor’s name ______________________

Address __________________________

__________________________________

__________________________________

Phone  ___________________________

Reason for this visit _________________

__________________________________

__________________________________

Symptoms/medical problem you are having

__________________________________

__________________________________

__________________________________

How long have you had this problem or
symptoms? ________________________

__________________________________

__________________________________

Questions you want to ask the doctor about
this problem or symptoms  ____________

__________________________________

__________________________________

List below all of the prescription
and non-prescription (OTC) medicines you are now taking.

(Show this list to your doctor during your visit)

Prescription Medicines

__________________________________

__________________________________

__________________________________

__________________________________

Over-the-Counter (non-prescription)
Medicines and Vitamins / Minerals,
Dietary / Herbal Supplements

__________________________________

__________________________________

__________________________________

__________________________________

At the Doctor’s Office

Record any diagnosis (name of the problem)
your doctor gives you ________________

__________________________________

__________________________________

__________________________________

Record the name and phone number of any
other doctor that you should see about your
medical problem

Name ____________________________

Phone ____________________________

Questions to Ask About
Prescription Medicines

(If my doctor prescribes medicine for me, here
are some important questions to ask)

1. What is the name of the medicine and
what is it for? ______________________

❑ brand name or the ❑ generic name?

2. How and when do I take it—and for how
long? ____________________________

3. What side effects should I expect, and
what should I do about them? _______

4. Should I take this medicine on an ❑
empty stomach or ❑ with food?
Is it safe to drink alcohol with this medicine
❑ yes or ❑ no

5. If it’s a once-a-day dose, is it best to take
it in the ❑ morning or ❑ evening?

6. What foods, drinks, or activities should I
avoid while taking this medicine? ______

7. Will this medicine work safely with any
other medicines I am taking? ❑ yes ❑ no

8. When should I expect the medicine to
begin to work, and how will I know if it is
working?

__________________________________

9. How should I store this medicine?

__________________________________

10. Is there any written information
available about the medicine?
❑ yes or ❑ no?
Is it available in large print or a language
other than English? ❑ yes or ❑ no?

__________________________________

After My Doctor’s Visit

Call your doctor immediately if you are
having any problems with your treatment.

Call your doctor or pharmacist if you think
you are having troubling side effects with
any medicine prescribed or recommended
for you.

Pharmacy _________________________

Phone ____________________________

Record the date and time for any scheduled
blood tests, x-rays, or other medical tests
ordered by your doctor

Test _____________________________

Phone ____________________________

Testing facility ______________________

Record the date and time of your next
doctor’s visit ______________________

Keep up to date
Use 1 sheet for each doctor you visit

NeedyMeds
be medwise
Patient Information and Education

BeMedWise Program at NeedyMeds
50 Whittemore St., PO Box 219
Gloucester, MA 01931
(978) 281-6666
www.bemedwise.org