# 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  ____________

_________________________________

_________________________________

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# 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 ____________________________

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# 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

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# 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 ______________________

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# Use 1 sheet for each doctor you visit

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# BeMedWise Program at NeedyMeds

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