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|  | This document is designed to help you get the most of your next medical appointment.   * Fill in the sections that apply to your circumstances * Consider sharing your notes with the doctor at your next appointment * You can print this document and fill in a hard copy, or fill it electronically using the Tab key to move from one field to the next |

We hope you find this tool useful, and we wish you a speedy recovery!

For a short video on this topic, click [here](https://share.vidyard.com/watch/r9jiNU3rkBrVR6m3KYrUAe) or use this link: https://share.vidyard.com/watch/r9jiNU3rkBrVR6m3KYrUAe

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| Doctor’s name | | | Specialty | | | |
| Appointment date and time | | | | | | |
| **If it’s an in-person appointment**  Address:  Time I have to leave at:  *Factor in anticipated traffic, time to park, bus schedule, other delays* | | | | | | |
| **If it’s a virtual appointment**  Contact information:  Private space where I will attend the call or videoconference: | | | | | | |
| Did I set a reminder for myself? | | | | | | |
| **Prescribed tests** | | | | | | |
| Test *(Blood tests, X-rays, ultrasound, etc.)* | | Date completed or appointment date | | | Hospital or clinic | |
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| **Questions for my doctor** | | | | | | |
| ***Write down your questions here, you can highlight the most important ones.*** | | | | | | |
| **My symptoms** | | | | | | |
| ***Write down symptoms such as pain, a depressed, sad or anxious mood, a drop in your energy level, trouble sleeping, digestive problems, etc. Note down how they vary throughout the day and what makes you feel better or worse.*** | | | | | | |
| **My lifestyle habits** | | | | | | |
| *Describe the habit, include quantity and frequency.* | | | | | | |
| Alcohol | |  | | | | |
| Nicotine | |  | | | | |
| Marijuana and other substances | |  | | | | |
| Exercise and sports | |  | | | | |
| Hobbies | |  | | | | |
| Sleep habits | |  | | | | |
| Other habits: | |  | | | | |
| **Other health care providers I’m seeing**  O*ther doctors, specialists, physiotherapist, chiropractor, psychologist, etc.* | | | | | | |
| Name | Specialty | | | Last appointment | | Next appointment |
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| **Medication, vitamins, supplements**  *List here, take a picture or ask your pharmacist for a list. Include over-the-counter drugs, even if used only on occasion.* | | | | | | |
| Name | | Dose and frequency | | | Is it working? Questions about it? Side effects | |
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| **Treatment I’ve had in the past** | | | | | | |
| Approximate date/year | | Treatment type (include medications) | | | Did it help? | |
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| **Other people I want to talk to about my appointment** | | | | | | |
| *List here (partner or spouse, family members, friends, disability case manager, other health care providers, others). Describe why you want to talk to them.* | | | | | | |
| **Notes** | | | | | | |