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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
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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**  |