

# Doctor Visit Prep Sheet

Visit date: \_\_\_\_\_

Fill in before the visit and take notes during it. **Bring this sheet and your medication list to every visit.**

## VISIT DETAILS

Patient name: \_\_\_\_\_

Doctor / office: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

## TOP 3 QUESTIONS OR CONCERNS TO ASK

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

## CHANGES SINCE THE LAST VISIT *(check one, add a short note)*

| Area                                 | Compared with last visit                                                                                                          | Notes (what, when) |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|--------------------|
| Memory / thinking                    | <input type="checkbox"/> Same <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> New concern |                    |
| Mood / behavior                      | <input type="checkbox"/> Same <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> New concern |                    |
| Sleep                                | <input type="checkbox"/> Same <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> New concern |                    |
| Appetite / weight                    | <input type="checkbox"/> Same <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> New concern |                    |
| Falls or injuries                    | <input type="checkbox"/> Same <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> New concern |                    |
| Bowel, bladder, or toileting changes | <input type="checkbox"/> Same <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> New concern |                    |
| Pain or other symptoms               | <input type="checkbox"/> Same <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> New concern |                    |

## CURRENT MEDICATIONS REVIEWED

Any changes: \_\_\_\_\_

Side effects noticed: \_\_\_\_\_

Refills needed: \_\_\_\_\_

## SINCE THE LAST VISIT

Other providers seen: \_\_\_\_\_

ER / hospital visits: \_\_\_\_\_

## NOTES FROM THE VISIT

Diagnoses discussed: \_\_\_\_\_

Instructions: \_\_\_\_\_

Medication changes: \_\_\_\_\_

Tests or referrals ordered: \_\_\_\_\_

## NEXT STEPS

Next appointment (date & time): \_\_\_\_\_

With: \_\_\_\_\_

Follow-up to-dos: \_\_\_\_\_

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