Getting Ready for Your Next Office Visit

AMERICAN LUNG ASSOCIATION®

Appointment Information

Provider Name: _____ Date: _____

Address: _____

Reason for Visit: _____

Other Healthcare Providers I Am Seeing

Name: _____ Phone: _____

Reason to see this healthcare provider: _____

Name: _____ Phone: _____

Reason to see this healthcare provider: _____

Name: _____ Phone: _____

Reason to see this healthcare provider: _____

Prescribed and Over-the-Counter Medicines and Supplements

Name of Drug/Supplement	Dose	Frequency	Prescribed/Recommended by

Name of My Pharmacy: _____ Phone: _____

Symptoms I Have Been Experiencing

Coughing		Feeling nervous	
Chest tightness		Rapid heartbeat	
Wheezing		Head/nose stopped up	
Unable to exercise		Restlessness	
Feeling tired		Fever	
Need to clear throat repeatedly		Stroking chin or throat	
Dry mouth		Increased use of quick-relief inhaler	
Waking up at night		Other:	

How frequently these symptoms occur:

When the symptoms begin:

Things I do to relieve these symptoms:

Additional Concerns and Questions

Next Steps

Notes from my healthcare provider:

Tests to schedule:

Next appointment (Day/Time):