



Getting Ready for Your Next Office Visit

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): _____