Follow-Up Office Visit Planner

I’m in active treatment / Routine follow-up

Appt. Date: __________  Location: ________________________________
Appt. Time: __________  Doctor: _________________________________

List of Current Medications / Supplements (include prescribing doctor and dosage)
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Current Side Effects and Symptoms
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Mental Health Concerns (depression, anxiety, etc.)
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Questions to Ask Your Doctor

How do you feel my treatment is working, and what is that based on? ________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Have there been significant changes in my lab work since my last visit? ________________________________
________________________________________________________________________________________
________________________________________________________________________________________

How do I know when it’s time to change treatment? Is it time to consider a new approach? ______________
________________________________________________________________________________________
________________________________________________________________________________________

Are there any treatment side effects that I should look out for? ________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Which symptoms/side effects should I notify you of immediately? ________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Who can I contact if I have further questions or concerns? (name, phone, email) ______________
________________________________________________________________________________________
________________________________________________________________________________________

Additional questions / notes
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

My Visit Checklist

☐ Can you record the audio of the visit?
☐ Bring a friend or family member to take notes
☐ Discuss your visit on the way home