Today’s Health Care Visit

A tool for patients and their health care providers
Today’s Health Care Visit

My Name: ________________________________________________

Today’s Date: _____________________________________________

Current list of my medications, pills and vitamins *(attach it for the doctor)*

I have a plan or drug card that pays for my medicine? Yes       No

Why am I at the doctor’s today?

*Things like illness, changes happening with family, staff or friends; need forms filled out; would like a check-up, need more medication etc….*)

Did I recently go see any other doctors or dentist?    Yes   No

Things I like:  Things I don’t like:
My biggest fear or worry about coming for health care is:

Some ways you can help me to better understand our visit are:

Speak Slowly: ☐  Repeat things: ☐  Talk to my caregiver too: ☐

Use Pictures: ☐  Write it down: ☐  Speak directly to me: ☐

Other: ☐

Have any of these been bothering me in the last week:

<table>
<thead>
<tr>
<th>Not sleeping well?</th>
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<tr>
<td>Not hungry?</td>
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<tr>
<td>Bath/washroom difficulties?</td>
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<tr>
<td>Emotional issues?</td>
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<tr>
<td>Feeling tired, no energy?</td>
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<tr>
<td>Mouth or teeth?</td>
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<tr>
<td>Sexual health?</td>
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<tr>
<td>Anything else?</td>
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</table>
Where does it hurt?

(Draw an ‘X’)

Understanding Today’s Visit:

My name: ________________________________
Doctor or Nurse’s name: _______________________
Date: ____________________________

Why did I see the Doctor today?

What did the Doctor or Nurse do?

What did the Doctor or Nurse find out?

Appointments & Follow-Up

Do I have any new appointments?

YES or NO

If Yes,
Doctor’s Name: ________________________________
Where: ________________________________
Reason: ________________________________
Date: ________________________________
Medications changes

Were there changes to my medication? YES or NO

If Yes:
1. **Medication Name: ___________________**
   - I am to take this _____ times per day.
   - I am to stay on this for ______ days
   - Reason Given: ________________________________

2. **Medication Name: ___________________**
   - I am to take this _____ times per day.
   - I am to stay on this for ______ days
   - Reason Given: ________________________________

I should come back to the Doctor if:

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Do I need any help getting or paying for my medication?

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Other information for me or my caregivers:

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Would I like a follow up phone call?  

Yes  

No
Do I need to do bloodwork or get a test I’m nervous about?

Here are some tips that might help!

• It’s OK to tell people that I am nervous or afraid.

• Ask the doctor or nurse to show me and explain what will happen before it happens.

• Bring something that helps me feel more comfortable.
  • Do I like listening to music?
  • Do I want to hold a ball or something squishy in my hand?

• Bring someone with me!
  • Hold their hand if I need to!

• Close my eyes.

• Turn my head, then look away at the wall.

• Count to 20.

• I can also ask any questions that I have!

• Be very proud of myself. I have been so strong and brave!