

Regular Checkup for a Lifelong Condition

You can complete the highlighted fields on this form online and then print the form for easy reference. Only text that is visible on the form is printed; scrolled text will not print. Any text you enter into these fields will be cleared when you close the form; you cannot save it.

Print this form and fill in the following information if this is a regularly scheduled appointment with your health professional.

What questions or concerns do I want addressed during this appointment?

Do I have any new symptoms? Yes No
 If yes, include how long I have had them and what helps relieve them. If I have pain, describe where it is, how it feels, and how severe it is.

Has there been a recent change in my normal routine (for example, sleeping, eating, recent death of a loved one, or divorce)? Yes No
 If yes, describe briefly:

Have I been diagnosed with any new disease or condition? If yes, fill in the following information: Yes No

| Condition or disease | Health professional who diagnosed the condition | What was the prescribed treatment? |
|----------------------|---|------------------------------------|
| | | |
| | | |

Have I had any recent medical tests (blood, urine, X-rays, or other tests) that this health professional did not order? If yes, fill in the following information: Yes No

| Name of test | Date | Results |
|--------------|------|---------|
| | | |
| | | |

Am I taking any prescription or over-the-counter medicines that my health professional is not aware of? If yes, fill in the following information: Yes No

| Name of medicine | Why am I taking it? |
|------------------|---------------------|
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|---|--------------------|-----|----|
| Do I have any new allergies to medicines, foods, or other substances? If yes, fill in the following information: | | Yes | No |
| Medicine or substance | My reaction | | |
| | | | |
| | | | |
| | | | |
| Treatment issues | | | |
| Have I had any difficulty carrying out my treatment for this condition? If yes, describe briefly: | | Yes | No |
| Have I had any recent stresses that may affect my ability to care for the condition I have? If yes, describe briefly: | | Yes | No |
| Do I need any special written information or instructions to help me care for the disease or condition I have, such as instructions about monitoring my blood sugar if I have diabetes? | | Yes | No |
| Are there any new treatments or tests for this condition? | | | |
| What are the benefits and risks of the new treatments or tests? | | | |
| What could happen if I choose not to have the new treatment or test? | | | |

Reminder

- Bring any records you have been keeping since your last visit, such as a blood sugar record if you have diabetes.



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