



## **DOCTOR APPOINTMENT CHECKLIST<sup>1</sup>**

Carolyn Wilken<sup>2</sup>

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**What is the primary reason for this appointment?**

\_\_\_\_\_  
\_\_\_\_\_

**Is this a new problem or symptom?**

\_\_\_\_\_

**Describe the symptoms or problems you are having?**

\_\_\_\_\_  
\_\_\_\_\_

**When are the symptoms most noticeable?**

\_\_\_\_\_  
\_\_\_\_\_

**What have you tried that has not helped relieve symptoms?**

\_\_\_\_\_  
\_\_\_\_\_

**This is affecting my daily life in these ways** \_\_\_\_\_

\_\_\_\_\_

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Prescription Medication	Dosage	Frequency	Over-the-Counter Drugs	Dosage	Frequency	Supplements and Vitamins	Dosage	Frequency

**Notes:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_