



### BEFORE MY VISIT

Date of visit: \_\_\_\_\_

Provider's name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Reason for this visit: \_\_\_\_\_  
\_\_\_\_\_

Symptoms/medical problem you are having: \_\_\_\_\_  
\_\_\_\_\_

How long have you had this concern? \_\_\_\_\_

Questions to ask your provider your concern: \_\_\_\_\_  
\_\_\_\_\_

List (on the inside page) all of the prescription and non-prescription (OTC) medications/supplements you are now taking. Share the list with your provider during your visit.

### DURING YOUR OFFICE VISIT

Record any diagnosis (name of concern) your provider gives you: \_\_\_\_\_  
\_\_\_\_\_

Record the name and phone number of other providers that you should contact regarding your concerns.

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

Phone: \_\_\_\_\_

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

Phone: \_\_\_\_\_

### IMPORTANT QUESTIONS TO ASK

#### Prescription Medicines

1. What is the name of the medicine and what is it for? \_\_\_\_\_

brand name or the  generic name?

2. How and when do I take it—and for how long?  
\_\_\_\_\_

3. What side effects should I expect, and what should I do about them? \_\_\_\_\_  
\_\_\_\_\_

4. Should I take this medicine on an  empty stomach or  with food? Is it safe to drink alcohol with this medicine  yes  no

5. If it's a once-a-day dose, is it best to take it in the  morning or  evening?

6. What foods, drinks, or activities should I avoid while taking this medicine? \_\_\_\_\_  
\_\_\_\_\_

7. Will this medicine work safely with any other medicines I am taking?  yes  no

8. When should I expect the medicine to begin to work, and how will I know if it is working?  
\_\_\_\_\_

Are there any tests required with this medicine (for example, to check liver or kidney function)?  
\_\_\_\_\_

9. How should I store this medicine?  
\_\_\_\_\_

10. Is there any written information available about the medicine?  yes  no?

Is it available in large print or a language other than English?  yes or  no?

### AFTER MY PROVIDER'S VISIT

- Call your provider immediately if you are having any problems with your treatment.
- Call your provider or pharmacist if you think you are having troubling side effects with any medicine prescribed or recommended for you.
- List your preferred pharmacy (on the inside page) and the phone number to that location.
- Date and time for any scheduled blood tests, x-rays, or other medical tests ordered by your provider.
- Test: \_\_\_\_\_
- Phone: \_\_\_\_\_
- Testing facility: \_\_\_\_\_
- Next appointment: \_\_\_\_\_



Knox Community  
HOSPITAL

PERSONAL  
MEDICATION RECORD



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