DOCTOR VISIT CHECKLIST

Date:	Appointment with:
My goals for this visit:	
My long term goals:	
Symptoms I've been having sin	ce my last visit:
Medications I am taking:	Supplements/ Vitamins I am taking:

Specific questions I have about my treatment: (Write answers underneath)
1.
<u>2.</u>
3.
<u>. </u>
4.
<u>5.</u>
<u>J.</u>
6.
Other information from my dector I need to remember
Other information from my doctor I need to remember: