UFT WELFARE FUND ---------- MEMBER AWARENESS PROGRAM

PRE- OFFICE VISIT GUIDE

COMPLETE THIS FORM PRIOR TO YOUR VISIT TO YOUR DOCTOR. TO PROTECT YOUR PRIVACY, DO NOT WRITE YOUR NAME ON THIS FORM.

Description of the problem: _____

When did this problem start? _____

At what time of day does the problem occur? _____

Has this ever happened before?: _____

What have you done to treat this problem?: _____

Have you seen another doctor and what was his/her diagnosis?: _____

_____

Are you taking any medications including over-the-counter drugs?: _____
You should complete and bring the MAP- Personal Medication Question Guide to the office visit.

FAMILY HISTORY

Are your parents alive? _____

Living Siblings? _____

If not, what was their cause of death? _____

PRIOR ILLNESSES

List any serious illnesses, surgeries that you have had and their approximate dates:

_____

AT THE OFFICE VISIT : REVIEW WITH THE DOCTOR

DIAGNOSIS: _____

COURSE OF TREATMENT: _____

MEDICATIONS PRESCRIBED AND INSTRUCTIONS: _____