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:

________________________________________________________________________