Tufts Medical Center

APPOINTMENT CHECKLIST

Prior to going to your appointment, use this checklist to ensure you have brought all you will need with you!

- ☐ **Insurance Card**
- ☐ **Form of Payment (for co-pay)**

Online Toolkit Forms

- ☐ **What You Want To Cover: Concerns, Goals and Questions**
- ☐ **Symptom Journal**
- ☐ **Medications Log**
- ☐ **Family History Log**
- ☐ **Vaccination Log**
- ☐ **Hospitalizations and Surgeries Log**
- ☐ **Health Problems Checklist**
- ☐ **Health Behaviors Checklist**
- ☐ **Females Only: Menstrual Period Checklist**

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WHAT YOU WANT TO COVER

What are your immediate concerns and/or goals for your visit? What questions do you want to make sure you ask? This form will help ensure you remember everything you want to cover!

CONCERNS: **My top three medical concerns, in order of importance to me are:**
1.
2.
3.

GOALS: **My goals for this appointment are:**
1.
2.
3.

QUESTIONS: **My questions for the doctor are:**
1.
2.
3.

If you are unsure what to ask, here are a few suggestions:

- What is my diagnosis? What else could it be?
- Why do you think this is my diagnosis (from test results/physical exam)?
- Could there be more than one thing going on?
- What do I need to do to feel better?
- Can you explain the test/medication/specialist you want me to have/see?
- When should you have the test results?
- What are the risks to the test/medication you are prescribing me? What happens if I do nothing?
- When do I need to follow up with you? How do I reach you (phone, email, online portal)?
- What should I do if my symptoms worsen or change or I don't respond to treatment?

Consider what is important to you about your relationship with your doctor. Express this at the visit.

- What are your information needs? Do you prefer directives or shared decision making?
- Does your doctor's personal style matter to you (formal, soft spoken, laid back, uses humor)?
- Is it important that your doctor matches your gender, race and/or age?
- Do you have a preference where he/she practices (small, large, academic or community setting)?

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SAMPLE

WHAT YOU WANT TO COVER

What are your immediate concerns and/or goals for your visit? What questions do you want to make sure you ask? This form will help ensure you remember everything you want to cover!

CONCERNS: **My top three medical concerns, in order of importance to me are:**
1. I have a radiating pain and cough that is not going away.
2. I would like to get a flu shot.
3.

GOALS: **My goals for this appointment are:**
1. Work with my doctor to form a plan of action to find out what is causing my symptoms.
2. Get an idea from my doctor as to what she thinks might be the cause of my pain.
3.

QUESTIONS: **My questions for the doctor are:**
1. What do you think is going on with me?
2. I've tried taking Tylenol but it isn't working, what do you recommend to relieve my symptoms?
3. What should my next steps be? And what are yours?

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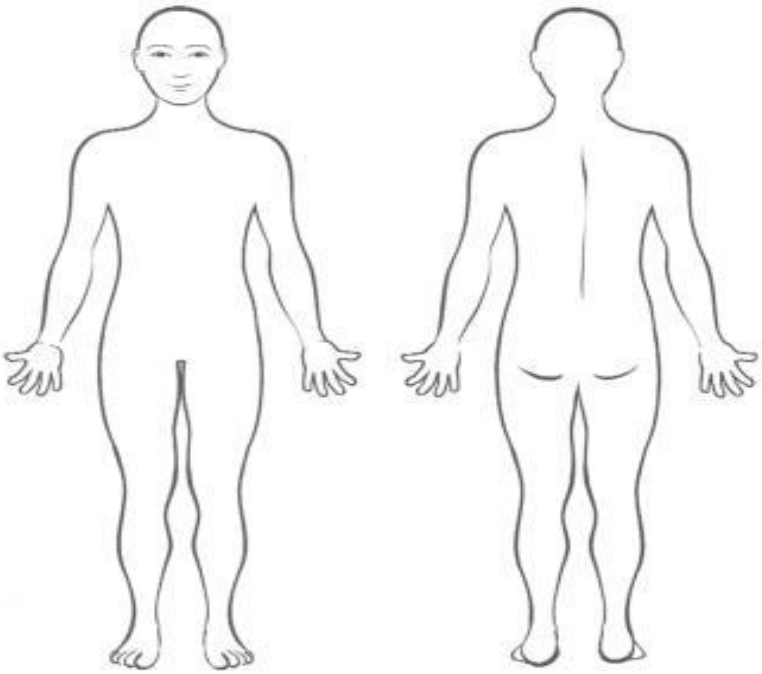
SYMPTOM JOURNAL

When you are not feeling well or are concerned about your health, explaining what is wrong may be hard to do. Journaling your symptoms will help you maximize your visit, enabling you to quickly answer questions.

Use the drawing to indicate your health changes:

1. Where is it? Mark the drawing with an X.
2. How would you describe your symptom? Add words near the X such as sharp, achy, dull, stabbing, tingling
3. Does the pain radiate to some other area? Draw an arrow to this second place.



	Symptom 1	Symptom 2	Symptom 3
My symptoms			
When it started			
How severe is the pain at its worst? (1-10, 1 being no pain)			
How severe is the pain right now? (1-10, 1 being no pain)			
Is the pain constant or does it come and go?			
What makes it better or worse? (Ex: exercise, eating, time of day)			
What I think caused this symptom (Ex: accident, new medication)			
How I have treated my symptom (Ex: Tylenol, other doctor)			
How it affects my daily routine			

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SAMPLE

SYMPTOM JOURNAL

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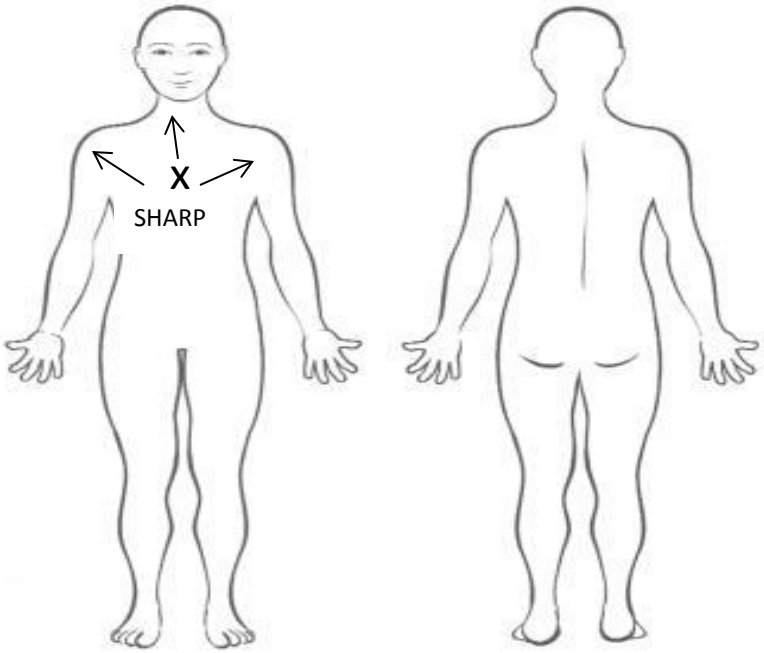

	Symptom 1	Symptom 2	Symptom 3
My symptoms	*Sharp pain in chest*	*Cough*	
When it started	*4 weeks ago when drinking alcohol*	*2 weeks ago*	
How severe is the pain at its worst? (1-10, 1 being no pain)	*8*	*2*	
How severe is the pain right now? (1-10, 1 being no pain)	*2*	*0*	
Is the pain constant or does it come and go?	*At first pain only with alcohol and sometimes shooting pain*	*Slightly when I cough, throughout the day*	
What makes it better or worse? (Ex: exercise, eating, time of day)	*Bending forward helps a little*	*Lying down makes it a little worse*	
What I think caused this symptom (Ex: accident, new medication)	*Thought it was alcohol, stopped drinking, now not sure*	*Not sure*	
How I have treated my symptom (Ex: Tylenol, other doctor)	*Went to chiropractor*	*Tylenol, every 4-6 hours when pain is bad*	
How it affects my daily routine	*Having trouble sleeping*	*My co-workers are complaining*	

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MEDICATIONS LOG

Use this chart to list all of the drugs and supplements that you take, even those not prescribed by a doctor. If you cannot do this or are unsure of the dosage, bring ALL of your medications or take a PICTURE of the front and back of the bottle to show the doctor. Some medications do not work well together or may not be needed at all.

My medications, herbs, vitamins, supplements	Dosage (Ex: two 40mg pills day & night)	How long I have used this?	What do I take it for?	If Rx, Who prescribed it?
Tri-Previfem	*1 pill a day*	*Started age 18*	*Birth control*	*Dr. Jane Gyno*
Multi-vitamin	*1 pill a day*	*3 months*	*Worried I'm not getting all the right vitamins I need in my diet.*	

ALLERGIES

Do you have any allergies? Yes ☐ No ☐

If yes, please list ALL allergies (Ex. Aspirin, Latex Gloves, Gluten, Pollen)?

_____ _____

_____ _____

_____ _____

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FAMILY HISTORY

Has anyone in your family (who is biologically related) *ever* been diagnosed with any of the following? This may involve asking family members so it is helpful to have this prepared before your visit.

	Self	Parent	Sibling	Grandparent	Aunt/Uncle	Age when Diagnosed	Don't Know
Cancer (*any type*)	☐	☐	☐	☐	☐	☐	☐
Easy Bleeding (Nose bleed, Heavy period)	☐	☐	☐	☐	☐	☐	☐
Blood Clots	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐
Diabetes (type I or II)	☐	☐	☐	☐	☐	☐	☐
Heart Procedure or Heart Attack	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐
Kidney Disease/ Dialysis	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐
Transplants	☐	☐	☐	☐	☐	☐	☐

Use the space below to add further details regarding any of the above diagnoses. If you have multiple family members who have been diagnosed with the same disease please list their relationship to you and their age at diagnosis:

Notes: _____

_____

_____

_____

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VACCINATION LOG

Consider obtaining your vaccination record(s) from your Pediatrician or PCP and using this handy tool to keep track of them. We suggest you update this log and keep it with the certificates of vaccinations as you receive them or attach it to the records you already have.

Are you up to date with your current vaccinations? Yes ☐ No ☐ Don't know ☐

Vaccine	Yes	No	Date of Most Recent
Tetanus (Td/Tdap) Tdap protects you from Tetanus (lockjaw), Diptheria (thick coating which forms in back of throat) and Pertussis (whooping cough).	☐	☐	
Pneumococcal Pneunmococcal disease is caused by bacteria which can lead to ear, lung (pneumonia), blood (bacteremia) or the covering of the brain and spinal cord (meningitis) infections.	☐	☐	
Meningococcal (Meningitis) Meningitis is a serious bacterial illness; an infection of the covering of the brain and spinal cord.	☐	☐	
HPV (Gardasil) The HPV (human papillomavirus) vaccine protects you from the HPV sexually transmitted virus which can cause cancer.	☐	☐	Shot 1: _____ Shot 2: _____ Shot 3: _____
Influenza (Flu Shot) The Flu is caused by the influenza virus which spreads every year, usually between October and May. It can lead to pneumonia and blood infections.	☐	☐	
Hepatitis A The Hep A virus causes a serious infection that affects the liver.	☐	☐	
Hepatitis B The Hep B virus causes a serious infection that affects the liver.	☐	☐	
Measles, Mumps & Rubella (MMR) This 3-in-1 vaccine protects you from a range of symptoms which can lead to infections, pneumonia, seizures, deafness, meningitis and death.	☐	☐	

Learn more about vaccines from the
U.S. Department of Health and Human Services Centers for Disease Control and Prevention.

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HOSPITALIZATIONS & SURGERIES LOG

Have you been hospitalized or had surgery in the past three months? Yes ☐ No ☐

If yes, please fill in this log:

Date you were treated	Place you were treated	Reason(s) you were treated

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HEALTH PROBLEMS CHECKLIST

Your doctor will likely cover this checklist, also known as the Review of Systems.
It is provided as a tool to help you recall any health problems you may have experienced in the past 3 months.

Often feeling tired (fatigued)	Yes ☐	No ☐	
Unexplained weight loss	Yes ☐	No ☐	
Unexplained weight gain	Yes ☐	No ☐	
Unexplained fevers or night sweats	Yes ☐	No ☐	
Rashes	Yes ☐	No ☐	
Changes with skin mole(s)	Yes ☐	No ☐	Location: _____
New lump(s)	Yes ☐	No ☐	Location: _____
Easy bruising or bleeding	Yes ☐	No ☐	
Frequent headaches	Yes ☐	No ☐	
Trouble with vision that is not corrected by glasses or contacts	Yes ☐	No ☐	Last eye exam: _____
Trouble with hearing	Yes ☐	No ☐	Last hearing test: _____
Frequent sinus congestion or "hay fever"	Yes ☐	No ☐	
Dental problems	Yes ☐	No ☐	Last dental exam: _____
Difficulty swallowing	Yes ☐	No ☐	
Rapid or irregular heart beat	Yes ☐	No ☐	
Chest pain	Yes ☐	No ☐	
Swelling or puffiness of feet or hands	Yes ☐	No ☐	
Shortness of breath	Yes ☐	No ☐	
Frequent cough	Yes ☐	No ☐	
Wheezing	Yes ☐	No ☐	
Loss of appetite	Yes ☐	No ☐	
Frequent nausea or vomiting	Yes ☐	No ☐	
Frequent heartburn	Yes ☐	No ☐	
Frequent abdominal pain	Yes ☐	No ☐	
Frequent diarrhea	Yes ☐	No ☐	
Frequent constipation	Yes ☐	No ☐	
Blood in stools	Yes ☐	No ☐	
Pain or burning with urination	Yes ☐	No ☐	
Need to urinate frequently	Yes ☐	No ☐	
Blood in urine	Yes ☐	No ☐	
Sexual problems	Yes ☐	No ☐	
Hot flashes	Yes ☐	No ☐	
Joint or bone pain	Yes ☐	No ☐	Location: _____
Frequent muscle aches	Yes ☐	No ☐	Location: _____
Other frequent pain	Yes ☐	No ☐	Location: _____
Tremors of hands	Yes ☐	No ☐	
Problems with coordination	Yes ☐	No ☐	
Seizures (convulsions)	Yes ☐	No ☐	
Dizziness	Yes ☐	No ☐	
Memory problems	Yes ☐	No ☐	
Often feeling sad or down	Yes ☐	No ☐	
Often feeling anxious or worried	Yes ☐	No ☐	
Frequent mood swings	Yes ☐	No ☐	
Trouble sleeping	Yes ☐	No ☐	

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HEALTH BEHAVIORS CHECKLIST

Your doctor is interested in your overall health and will ask you about some of the behaviors you engage in. Don't be put off, this is routine. Try to answer honestly, your doctor is there to help you, not judge you. Here are some of the questions you may be asked:

Drugs:

1) **Do you smoke cigarettes or use tobacco products?** Yes ☐ No ☐

   If yes, age started? ____ **Packs per day?** ____

2) **Does anyone in your household smoke?** Yes ☐ No ☐

   If yes, who? _____

3) **Do you use any recreational drugs (including marijuana)?** Yes ☐ No ☐

Alcohol:

1) **Do you drink beer, wine, or liquor?** Yes ☐ No ☐

   If yes, how many alcoholic beverages do you consume in an average week?

   Less than 1: ☐ 1-3: ☐ 4-6: ☐ More than 6: ☐

Tanning:

1) **Do you lie in the sun to tan?** Yes ☐ No ☐

2) **Do you go to tanning studios?** Yes ☐ No ☐

3) **Do you use sunscreen?** Never ☐ Sometimes ☐ Always ☐

Exercising:

1) **Do you consider yourself physically active?** Yes ☐ No ☐

2) **How often do you exercise?**

   Never ☐ Less than once/week ☐ 1-2 times/week ☐ 3+ times/week ☐

3) **Are you able to keep up with your friends when doing physical activity?** Yes ☐ No ☐

4) **How do you perceive your current weight?** Underweight: ☐ Normal Weight: ☐ Overweight: ☐

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FEMALES ONLY: MENSTRUAL PERIOD CHECKLIST

This checklist helps prepare you for your annual physical or gynecologist appointment.

1) **Have you had a menstrual period during the past year?** Yes ☐ No ☐

If yes, what was the date of your last menstrual period? _____

How often are your periods? Every _____ days

How long do your periods last? _____ days

Is your cycle: Regular ☐ Irregular ☐

Is your menstrual flow: Light ☐ Moderate ☐ Heavy ☐

Are you menstruating today? Yes ☐ No ☐

Today's date: _____

2) **Have you had a pelvic exam, Pap smear, or breast exam in the past year?** Yes ☐ No ☐

If yes, please list date and doctor: _____

3) **Do you take birth control pills or other hormones?** Yes ☐ No ☐

If yes, please list: _____

4) **Do you perform breast self-examination?**

No ☐ Yes, occasionally ☐ Yes, once a month ☐

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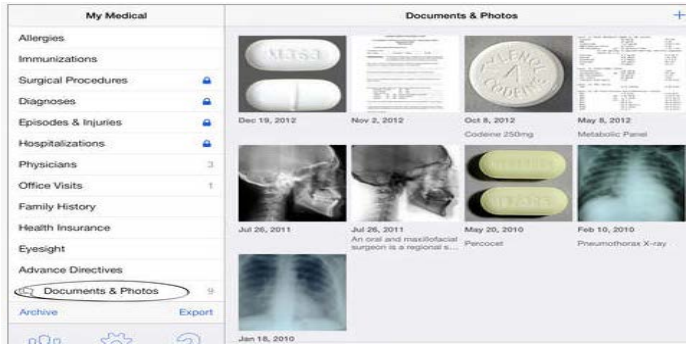
SUGGESTED RECORD KEEPING APPS

If you are looking for a digital method to keep track of your medical records you may want to try one of these applications:

My Medical:

Access: Download My Medical on your Mac or on your smart phone.
Cost: The trial version is Free. It is fully functional except for restrictions on the amount of information you can store. Try the trial size, a cost is incurred if you need to add more storage space.
Good to know: Data you enter is stored on your device, not on a remote server. The record keeping database does not connect to the Internet.
What you can use it for:

- The whole family (store multiple medical records)
- Contact information (for emergencies, doctors and health insurance)
- Photographs, lab work and x-rays
- Tracking test results (range of common test result templates are provided)
- Chart feature (to help you track trends over time)



Care Zone:

Access: Sign up online or download the application onto your smart phone.
Cost: The application is free.
Good to know: Care Zone highlights that it is dedicated to your privacy and security.
What you can use it for:

- Medications (list medications, dosages and schedules, track your adherence over time)
- Journal (document symptoms, record doctor's instructions, share updates with family members privately)
- Calendar (keep track of appointments and refills)
- Contacts (organize and share important contacts, numbers and emails)
- Photos and files (store discharge instructions or photos of important documents)

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DOCTOR CONTACT LIST

Do you have your doctor's number readily available if you need it?
Keep track of your doctor's contact information by
adding it in your phone's contact list, taking his/her business card or using this list:

Doctor's name: _____

Hospital/Practice: _____

Specialty: _____

Address: _____

Phone: _____ **Fax:** _____

Email: _____

Website: _____

Best way to contact him/her: _____

Doctor's name: _____

Hospital: _____

Specialty: _____

Address: _____

Phone: _____ **Fax:** _____

Email: _____

Website: _____

Best way to contact him/her: _____

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APPOINTMENT SUMMARY

This summary used in conjunction with "What You Want to Cover" and the "Symptom Journal" provides you with a comprehensive record of each health concern and interaction you have with your provider.

Appointment date & time: _____

Doctor's name: _____

Reason for appointment: _____

_____

Medication(s) prescribed/Changes to my current medications: _____

_____

Test(s) prescribed (date scheduled): _____

_____

Specialist(s) referred to (date scheduled): _____

_____

Notes from appointment: _____

_____

_____

Recommended Next Steps: _____

_____

_____

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HEALTH INSURANCE INTERACTION LOG

This form can be used to keep track of your calls with your insurance company.

Date & time: _____

Representative's name: _____

Reason for call: _____

_____

_____

Notes: _____

_____

_____

_____

Next Steps: _____

_____

_____

_____

For information on Understanding Your Insurance Benefits, Billing Information, Quick Tips to Ensure a Smooth Billing Process and Financial Assistance please visit Tufts Medical Center's Billing + Insurance web page.