

How Well Do You Know Yourself?

1. What is your medical condition?

Describe _____

2. How does your diagnosis affect your daily activities?

Describe _____

3. What are your "warning signs" that you need to see a doctor?

Describe _____

4. Does your medical condition require any special procedures?

Describe _____

5. Do you follow a special diet?

Describe _____

6. Do you use any adaptive equipment, orthotics, or prosthetics?

If so, what and why?

7. What medications do you use?

Name? _____

Reason? _____

Dosage? _____

Time? _____

Potential side effects? _____

Name? _____

Reason? _____

Dosage? _____

Time? _____

Potential side effects? _____

Name? _____

Reason? _____

Dosage? _____

Time? _____

Potential side effects? _____

Name? _____

Reason? _____

Dosage? _____

Time? _____

Potential side effects? _____

Name? _____

Reason? _____

Dosage? _____

Time? _____

Potential side effects? _____

Name? _____

Reason? _____

Dosage? _____

Time? _____

Potential side effects? _____

8. What do you do if you miss a dose? _____

9. Do you have special treatments, routine labs, or therapies?

What? _____

Why? _____

Who provides? _____

How often? _____

10. Who is your Primary Care Physician/Doctor? (Name, Address, & Phone)

11. What types of specialists do you see? (Specialty, Name, Address & Phone)

12. What pharmacy do you use? (Name & Phone)

13. What is your social security number? _____

14. What are your insurance plans?

Primary Insurance Company: _____

Policy Number: _____ Phone Number: _____

Who is the Primary Insured on Policy? _____

Secondary Insurance Company: _____

Policy Number: _____ Phone Number: _____

Who is the Primary Insured on Policy? _____

Other Insurance Company: _____

Policy Number: _____ Phone Number: _____

Who is the Primary Insured on Policy? _____

15. What do you do to prepare for an appointment with your doctor?

Describe _____

16. Under what circumstances would you call 911?

Describe _____
