American Lung Association.

Getting Ready for Your Next Office Visit

Appointment Information

Provider Name: _____

Date: _____

Address: _____

Reason for Visit: _____

Other Healthcare Providers I Am Seeing

Name: _____ Phone: _____

Reason to see this healthcare provider: _____

Name: _____ Phone: _____

Reason to see this healthcare provider: _____

Name: _____ Phone: _____

Reason to see this healthcare provider: _____

Prescribed and Over-the-Counter Medicines and Supplements

Name of Drug/Supplement	Dose	Frequency	Prescribed/Recommended by

Name of My Pharmacy: _____ Phone: _____

Symptoms I Have Been Experiencing

Coughing		Feeling nervous	
Chest tightness		Rapid heartbeat	
Wheezing		Head/nose stopped up	
Unable to exercise		Restlessness	
Feeling tired		Fever	
Need to clear throat repeatedly		Stroking chin or throat	
Dry mouth		Increased use of quick-relief inhaler	
Waking up at night		Other:	

How frequently these symptoms occur: _____

When the symptoms begin: _____

Things I do to relieve these symptoms: _____

Additional Concerns and Questions

_____

_____

_____

Next Steps

Notes from my healthcare provider: _____

_____

Tests to schedule: _____

_____

Next appointment (Day/Time): _____