ADAPT: A Doctor's Appointment Prep Tool

My doctor is: _____

The clinic is located at: _____

My appointment date and time is: _____

Before Your Appointment, You Can…

Call your doctor's office to ask about **wait times**, and if you need to **cancel an appointment**.

Bring **friends, family** or **interpreters**.

Write down **symptoms and questions** for your doctor.

Take pictures of your medications to bring to your appointment.

Do you need to bring anything to your appointment?

Medications: _____

Paperwork/Records: _____

Other: _____

At Your Appointment

You will likely **wait** before you see the doctor and **fill out paperwork**.

The nurse may do some **measurements** like blood pressure, weight and height.

Do you have questions for the doctor?

1. _____
2. _____
3. _____

After the Appointment, You Can…

Ask staff to write down any information you need.

Schedule a follow up appointment with the receptionist.

Book follow-up testing at a laboratory.

Ask if your insurance covers the cost of medications.

See test results and vaccine history online at My Health Records.

Call **Healthlink (811)** to ask if you need to visit the hospital.

What do you need to do after the appointment?

_____

Why are you seeing the doctor?

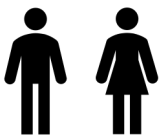
_____

How are you feeling? _____

1. Can you describe what is happening? _____
2. Why do you think this is happening?

   _____
3. When did this start? _____ How long has this been for? _____
4. Is this the first time this has happened? ❑ Yes ❑ No
5. Does anything make it better? ❑ Yes ❑ No _____
6. Does anything make it worse? ❑ Yes ❑ No _____

Have you noticed any of the following changes?

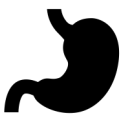


GENERAL

1. Pain: ❑ Yes ❑ No
2. Tired: ❑ Yes ❑ No
3. Weight Loss: ❑ Yes ❑ No
4. Fever: ❑ Yes ❑ No
5. Difficulty Sleeping: ❑ Yes ❑ No
6. Skin Changes: ❑ Yes ❑ No
7. Bleeding: ❑ Yes ❑ No
8. Change in Menstruation: ❑ Yes ❑ No

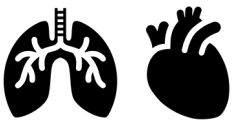
MOOD & THINKING

1. Forgetting Things Often: ❑ Yes ❑ No
2. Feeling Sad/Unhappy: ❑ Yes ❑ No
3. Feeling Worried: ❑ Yes ❑ No



DIGESTION

1. Difficulty Swallowing: ❑ Yes ❑ No
2. Nausea/Vomiting: ❑ Yes ❑ No
3. Urinary Changes: ❑ Yes ❑ No
4. Bowel Changes: ❑ Yes ❑ No



BREATHING AND HEART

1. Chest Pain: ❑ Yes ❑ No
2. Cough: ❑ Yes ❑ No
3. Difficulty Breathing: ❑ Yes ❑ No
4. Fast Heartbeat: ❑ Yes ❑ No

OTHER

_____

Have you ever had any of the following?

Existing chronic medical conditions? ❑ Yes ❑ No

If yes, what medical conditions do you have (e.g. high blood pressure, heart disease)?

_____

Hospitalizations? ❑ Yes ❑ No What for? _____

Travelled in the past year? ❑ Yes ❑ No Where to? _____

Allergies to medications? ❑ Yes ❑ No To what? _____

Are you currently employed? ❑ Yes ❑ No

Who can support you at home? _____

Alberta SPOR SUPPORT Unit Patient Engagement Platform
ICN Imagine Citizens Network Collaborating for health
ALBERTA MEDICAL ASSOCIATION
MD MD Financial Management