PREPARING FOR YOUR DOCTOR'S APPOINTMENT
PATIENT SAFETY CHECKLIST

Use this form to get ready for your next doctor's visit. Give this completed form to your doctor or nurse. *Keep a copy of this form in your file.*

ABOUT WHO YOU ARE

Patient's full name: Today's Date:

Patient's date of birth If younger than 18 years old give legal guardian name:

Patient does not speak or understand English. *This form was filled out by:*

Patient's primary or spoken language:

Reason(s) for the appointment:

ABOUT YOUR SUPPORT PERSON

Name of the person that goes with you to your doctor's appointment

What is this person's relationship to you? Family member Friend Other

Phone number of the person bringing you to your appointment

ABOUT YOUR TRANSPORTATION

How do you get to your doctor's appointment? (Please check)

_____Drive myself _____Take a bus or cab _____Ask someone to drive me _____Walk _____Bicycle

ABOUT YOUR EDUCATION

Check the highest grade you have completed in school: (this will help the doctor and nurse give instructions to you)

____Grade 1 through 5 _____ Grade 6 through 8 ____ Grade 9 through 12

____Years of college completed _____Years of vocational training completed ____Other education or training

ITEMS YOU SHOULD BRING WITH YOU TO YOUR DOCTOR'S VISIT

- ✓ Identification card with your picture
- ✓ Insurance card and/or Medicare card, if applicable
- ✓ Hospital or clinic card
- ✓ A copy of this Checklist
- ✓ All your medicine bottles including herbs, vitamins
- ✓ Medication checklist
- ✓ Medical records if needed, xrays, blood work, etc.

ABOUT YOUR MEDICAL AND FAMILY INFORMATION

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HAP Patient Safety and Hospital Quality Committee

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List any food or medicine allergies you have:

1. _____
2. _____
3. _____

List any vitamins, herbs, and special diet, you're on or taking.

1. _____
2. _____
3. _____

Check the problems you currently have.

__ Arthritis
__ Cancer
__ Fear of closed spaces
__ Eating problem
__ Hearing problem
__ Mental illness
__ Constipation or diarrhea
__ Pacemaker for heart or other implanted devices
__ Pregnancy
__ Problem walking, standing, bending, moving
__ Trouble remembering things
__ Trouble sleeping
__ Other: describe_____

Check the problems your family has had (parent, aunt, uncle, brother, sister, grandparent).

__Heart disease
__Diabetes
__Sleep problems
__Seizures
__High blood pressure
__Dizziness, fainting
__Depression/mental illness
__Infectious disease
__Anemia (low iron)
__Migraine headaches
__Eye problems
__Cancer
__Smoking or chewing tobacco
__Stomach/Bowel disease
__Kidney disease
__Breathing/lung
__Frequent pneumonia
__Complications with anesthesia (medicine used during surgery to put patients to sleep)
__Other:_____

ABOUT YOUR MEDICAL CHOICE

Have you made a choice about the medical care you want to receive, in case you are too sick to make a decision (Advance Directive)? _____Yes _____No _____ Don't know

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