# Patient Visit Check List

**Date:** ____ / ____ / ____

*Use this checklist to help guide your visit with your healthcare provider. After your visit, you can keep this checklist as a reminder of what you talked about and to track your current health and wellbeing.*

**What are your top 2 health concerns you want your doctor to know about:**

1. _____

2. _____

## Pre-Visit Checklist

*Please read each question below and circle "Yes" or "no" based on your response. Use this checklist to guide your conversation with your provider about any concerns or questions you may have.*

| Check-In Questions | Response |
|---|---|
| Have you seen any specialists since your last primary care visit? | Yes No |
| Have you experienced any falls since your last visit? | Yes No |
| Have you received your annual flu shot? | Yes No |
| Have you noticed any changes in your physical or mental health? | Yes No |
| Are you having any issues getting medication refills, or any new symptoms you think may be caused by your medication? | Yes No |
| Do you have any concerns about bladder control or issues with leakage of urine? | Yes No |
| Do you have any questions about x-rays, lab tests, or other results? | Yes No |
| Do you have any questions regarding any recent referrals or prior authorizations? | Yes No |

**Notes:**

# Patient Visit Check List

## Post-Visit Checklist

*Based on today's visit, check the box next to each action discussed with your provider.*

| Action Taken During my Visit Today | Completed? |
|---|---|
| My provider listened carefully to my concerns and gave me time to talk. | ☐ |
| My provider explained things in a way that was easy for me to understand. | ☐ |
| My provider reviewed my recent test or lab results and explained when and how I will receive any future results. | ☐ |
| My provider reviewed all the medications I take, answered my questions, and addressed refills, access, or side effects. | ☐ |
| My provider talked with me about my care needs beyond today's visit, including follow-up appointments, tests, or referrals. | ☐ |
| My provider asked about pain or other symptoms I am experiencing and discussed options to help manage them. | ☐ |
| My provider assessed my risk of falling and shared steps to help keep me safe. | ☐ |
| My provider discussed my physical health, including activity or exercise, in a way that fits my lifestyle and abilities. | ☐ |
| My provider checked in on my mental or emotional health and discussed support if needed. | ☐ |
| I left today's visit knowing the next steps in my care and who to contact if I have questions. | ☐ |

**Notes:**