Health Care Provider Communication Worksheet

Patient Information

Patient's Name: Date of Birth:

Health Insurance:

Medications currently taking Dosage

1. _____
2. _____
3. _____
4. _____
5. _____

Allergies to (medication & environment) Reaction

1. _____
2. _____
3. _____

Medical History Information (e.g. preexisting conditions, prior hospitalizations…)

Health Care Provider Information

What days/hours is the office open?

Days: Hours:

Who should I call for a medical emergency?

Name: Phone:

Which methods of communication does the provider prefer? (e.g. e-mail, phone…)

E-mail: Phone:

Who can answer my questions when the provider is not available?

Name: Phone:

Who do I call after hours?

Name: Phone:

Current Issues

Symptom How often Severity (0 -10; 10=worst) What makes it better/worse

1. _____
2. _____
3. _____
4. _____

Physical functioning problems Severity (0 -10; 10=worst) What makes it better/worse

1. _____
2. _____
3. _____

Emotional concerns:

Financial concerns:

Other concerns:

(Keep a copy for your record.)

Current Treatment Plan

New medications (dosage, time, route) Possible side effects

1. _____
2. _____
3. _____

Possible new symptoms Managing tips When to call provider

1. _____
2. _____
3. _____
4. _____

Notes on treatment plan: