

HEALTH SYMPTOMS/PROBLEMS

The value of doctor-patient relationship in improving your quality of care and ultimately your quality of life is invaluable. Often, your primary care visit will begin with the reason for your visit. You may have new symptoms or you just are not feeling “right”. It helps to write down when the symptoms started and what you are experiencing. Please print this tracker and bring it with you to your appointment. Of course, always call your doctor as soon as you experience any change that seems significant. If it feels like an emergency, take action immediately and go to the hospital. Please notify your doctor (or ask a family member to do so if you are unable to call), so we can follow-up.

New Symptom or Change #1

Describe: _____

When it started: _____

What you were doing when it 1st started:

- | | | | |
|--------------------------------------|-----------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Walking | <input type="checkbox"/> Exercising | <input type="checkbox"/> Laying down |
| <input type="checkbox"/> Standing up | <input type="checkbox"/> Drinking | <input type="checkbox"/> Eating | <input type="checkbox"/> Sleeping |

How often it happens:

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> All the time | <input type="checkbox"/> Couple times a day | <input type="checkbox"/> Couple times a week |
| <input type="checkbox"/> Day & night | <input type="checkbox"/> Only at night | <input type="checkbox"/> Only during the day |

New Symptom or Change #2

Describe: _____

When it started: _____

What you were doing when it 1st started:

- | | | | |
|--------------------------------------|-----------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Walking | <input type="checkbox"/> Exercising | <input type="checkbox"/> Laying down |
| <input type="checkbox"/> Standing up | <input type="checkbox"/> Drinking | <input type="checkbox"/> Eating | <input type="checkbox"/> Sleeping |

How often it happens:

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> All the time | <input type="checkbox"/> Couple times a day | <input type="checkbox"/> Couple times a week |
| <input type="checkbox"/> Day & night | <input type="checkbox"/> Only at night | <input type="checkbox"/> Only during the day |