WhatHappensNow.com
GUIDING YOU THROUGH

Medical Appointment Tracking Form

Date created:

Take time to fill out this form. Print as many pages or copies as needed for each appointment.

Patient Information

Today's Date/Time: _____
Patient Name: _____
Height/Weight: _____
Blood Pressure: _____
Reason for Appointment: _____

Symptoms/Complaints: _____

Doctor: _____
Name of Medical Facility: _____
Address: _____

Phone Number: _____

X-Rays

Reason: _____
Date/Time of Test: _____
Date/Time Results Due: _____
Date/Time You Discussed with Medical Staff: _____

Results/Next Steps: _____

Reason: _____
Date/Time of Test: _____
Date/Time Results Due: _____
Date/Time You Discussed with Medical Staff: _____

Results/Next Steps: _____

Test #1

Kind of Test/How will it help? _____

Location/Room of test: _____
Reason/What are they taking the test for: _____

Date/Time of Test: _____
Date/Time Results Due: _____
Date/Time You Discussed with Medical Staff: _____

Results/Next Steps: _____

Test #2

Kind of Test/How will it help? _____

Location/Room of test: _____
Reason/What are they taking the test for: _____

Date/Time of Test: _____
Date/Time Results Due: _____
Date/Time You Discussed with Medical Staff: _____

Results/Next Steps: _____

Test #3

Kind of Test/How will it help? _____

Location/Room of test: _____
Reason/What are they taking the test for: _____

Date/Time of Test: _____
Date/Time Results Due: _____
Date/Time You Discussed with Medical Staff: _____

Results/Next Steps: _____

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Medical Appointment Tracking Form page 2

Medication #1

Name of Medication/Dosage/Schedule Taken:

Date/Time Medication Ordered:
Has Dr. gone over your current meds with you to be sure there are no reactions or concerns:

Kind of medication? (narcotic, etc.):

How will it help/What are intended results?:

Date and time results will be seen?:

What are possible side effects?:

Will side effects be obvious and how so?:

Estimated date and time side effects go away?:

Medication #2

Name of Medication/Dosage/Schedule Taken:

Date/Time Medication Ordered:
Has Dr. gone over your current meds with you to be sure there are no reactions or concerns:

Kind of medication? (narcotic, etc.):

How will it help/What are intended results?:

Date and time results will be seen?:

What are possible side effects?:

Will side effects be obvious and how so?:

Estimated date and time side effects go away?:

Medication #3

Name of Medication/Dosage/Schedule Taken:

Date/Time Medication Ordered:
Has Dr. gone over your current meds with you to be sure there are no reactions or concerns:

Kind of medication? (narcotic, etc.):

How will it help/What are intended results?:

Date and time results will be seen?:

What are possible side effects?:

Will side effects be obvious and how so?:

Estimated date and time side effects go away?:

Additional Notes

Next Appointment

Date/Time of Appointment:
Reason for Appointment:

Doctor:
Name of Medical Facility:
Address:

Phone Number: