

APPOINTMENT CHECKLIST

DATE:

1 TODAY'S MAIN GOAL

WHAT YOU MOST NEED HELP WITH

- | | | | |
|-----------------------------|--------------------------|--------------------------|--------------------------|
| WORSE/ NEW SYMPTOMS | ☐ | HEART/ CHEST PAIN | ☐ |
| PAIN/ DISCOMFORT | ☐ | SHAKY/ FAINT | ☐ |
| FATIGUE/ ENERGY | ☐ | MEDICATIONS | ☐ |
| SLEEP/ INSOMNIA | ☐ | TESTS/ RESULTS | ☐ |
| BRAIN FOG/ FOCUS | ☐ | REFERRAL | ☐ |
| STOMACH/ BOWEL UPSET | ☐ | WORK/ STUDY | ☐ |
| BREATHING/ COUGH | ☐ | FORMS/ LETTERS | ☐ |
| DIZZY/ COORDINATION | ☐ | OTHER: | ☐ |

TOP THINGS FOR TODAY:

2 SINCE LAST TIME

HOW HAVE YOU BEEN?

- | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|
| ☐ | ☐ | ☐ | ☐ |
| | | | |
| BETTER | SAME | MIX | WORSE |

3 WHAT'S NEW?

WHAT YOU THINK THE CAUSE IS

REMEMBER TO NOTE ANY FAMILY HISTORY

- | | | |
|--|----------------------------|--------------------------|
| | CHANGE IN CONDITION | ☐ |
| | INJURY | ☐ |
| | INFECTION | ☐ |
| | MEDICATION | ☐ |
| | STRESS | ☐ |
| | ACTIVITY/ EXERTION | ☐ |
| | DIET | ☐ |

4 DAILY LIFE IMPACT

WHAT IS CURRENTLY AFFECTED BY YOUR SYMPTOMS

- | | | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | | | | | | |
| COOKING | EATING | HYGIENE | WORK | DRIVING | SOCIAL | ACTIVITY | SLEEP |

CURRENT ACTIVITY LEVEL

- | | | | | | | | | | | | |
|-----------------|--------------------------|-------------------|--------------------------|------------------|--------------------------|------------------|--------------------------|------------------|--------------------------|---------------|--------------------------|
| | ☐ | | ☐ | | ☐ | | ☐ | | ☐ | | ☐ |
| BEDBOUND | | HOUSEBOUND | | SOMETIMES | | PART-TIME | | FULL-TIME | | VARIES | |

5 MEDICATIONS/SUPPLEMENTS

ANYTHING YOU'RE TAKING FOR THESE SYMPTOMS

NAME & DOSE	REASON	NOTES
NAME & DOSE	REASON	NOTES
NAME & DOSE	REASON	NOTES
NAME & DOSE	REASON	NOTES

6 YOUR DETAILS

HEALTHCARE SUPPORTS

- | | | |
|--|------------------------------|--------------------------|
| | MEDICAL CARD | ☐ |
| | GP VISIT CARD | ☐ |
| | DRUGS PAYMENT SCHEME | ☐ |
| | CARER/ HELPER AT HOME | ☐ |

INSURANCE PROVIDER:

POLICY NUMBER:

7 WHAT'S NEXT?

PLAN FROM TODAY

TEST/SCAN TYPE & DATE

ARE YOU COVERED FOR IT?

YES: ☐ NO: ☐ SOME: ☐

MEDICATION CHANGES

NEXT APPOINTMENT DATE:



SCAN QR CODE:



OR VISIT:
WWW.BEDHEADPACING.COM

8 NOTES TO REMEMBER

BEDHEAD
PACING