

PATIENT SAFETY CHECKLIST

It is important to be prepared for your medical appointment. You must provide accurate information about your health problems and concerns. This checklist will help you write down information your doctor and nurse may need. Please fill out checklist before your next appointment and give it to your doctor or nurse at your appointment. Keep information on this form private.

1. INFORMATION ABOUT YOUR APPOINTMENT

Patient does not speak or understand English.

Today's Date: (mm)__(dd)__(yy)___

This checklist was filled out by: _____

Is the Patient younger than 18 year old?: Yes No

If yes, provide name of responsible, legal guardian of Patient: _____

Patient's Full Name: _____

Name of Primary Person going to _____
appointment with Patient and check box: family or friend

Name of Doctor to visit: _____

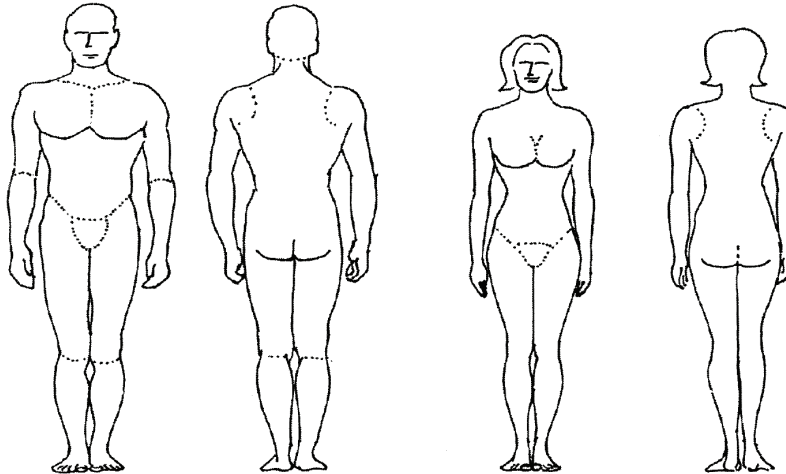
Location of Appointment: _____
(Hospital, clinic, floor, room number)

Date of Appointment: _____ Time of Appointment: _____ (AM) or (PM)

How will you get to the appointment? Drive myself Ask someone to drive me Take bus or cab

Reason(s) for Appointment: _____

In the picture below, circle part(s) of your body that you have problem(s) with:



Be sure to bring these items to your appointment:

- Identification card with picture
- Insurance card(s)
- Hospital or clinic card
- Medicare card, if appropriate
- This Patient Safety Checklist
- All medicine bottles
- Medical records, x-ray, CT scan, MRI scan, if appropriate

2. EMERGENCY CONTACT INFORMATION

Name of Emergency Contact: _____ family or friend Phone: _____

Do you have Medical Power of Attorney and/or Medical Directives (Living Will, etc.)?

No I would like more info on this and will contact my doctor.

Yes I will bring a copy of these documents to my appointment!

My primary doctor's name is: _____ Phone: _____

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3. INFORMATION ON CURRENT MEDICATIONS

- I AM TAKING THESE CURRENT MEDICATIONS! Write the names of each medicine from your medicine bottles.
Be sure and list all the prescribed and over-the-counter medicine that you are NOW taking.

Name of medicine	Dosage (e.g. 5 mg)	How Often? (e.g. 2 times/day)	I have to take this medicine forever.
1. _____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. _____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. _____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. _____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. _____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. _____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. _____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. _____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. _____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. _____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

(If you have more medications, please use an additional sheet.)

4. INFORMATION ABOUT ALLERGIES, EXISTING CONDITIONS AND FAMILY HISTORY

- LIST ANY FOOD OR DRUG ALLERGIES OR REACTIONS YOU HAVE OR HAVE HAD!
(List even if reaction was minor)
- LIST ANY SUPPLEMENTS, VITAMINS OR ALTERNATIVE MEDICINE AND/OR SPECIAL DIETS YOU ARE ON! (such as Atkins, South Beach, vegan, weight watchers, and special teas)

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

I CURRENTLY HAVE THE FOLLOWING CONDITION(S):

- | | | |
|--|---|--|
| <input type="checkbox"/> Hearing problem | <input type="checkbox"/> Pacemaker or implanted cardioverter or defibrillator | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Seeing problem | <input type="checkbox"/> Chemotherapy and radiation therapy for cancer | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Eating problem | <input type="checkbox"/> Problem moving/standing/bending | <input type="checkbox"/> Fear of closed spaces |
| <input type="checkbox"/> Arthritis, pain in joints | <input type="checkbox"/> Trouble remembering things | <input type="checkbox"/> Other: _____ |

I HAVE THE FOLLOWING FAMILY MEDICAL HISTORY:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stomach/Bowel disease | <input type="checkbox"/> Eye problem (glaucoma, cataract) |
| <input type="checkbox"/> Diabetes I or II | <input type="checkbox"/> Depression/Mental illness | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Smoking cigarettes or chewing tobacco |
| <input type="checkbox"/> Sleep problem(s) | <input type="checkbox"/> Infectious disease/STD | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Complication with blood transfusion |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Anemia | <input type="checkbox"/> Breathing/lung disease | <input type="checkbox"/> Complication with anesthesia |
| <input type="checkbox"/> Dizziness, fainting | <input type="checkbox"/> Migraine headache | <input type="checkbox"/> Recurring pneumonia | <input type="checkbox"/> Cancer (specify): _____ |

PLEASE BRING THIS FORM WITH YOU TO YOUR APPOINTMENT.

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