



# Navigating Your Clinic Visits

Please leave a copy with your Healthcare Provider

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Next Clinic Visit Date: \_\_\_\_\_

## CURRENT MEDICATIONS

List all medications that the patient is taking for Duchenne muscular dystrophy as well as other conditions, if applicable.

• Have there been any changes to the patient's medications since you last reported them to your doctor?  Yes  No  
If yes, please list the changes: \_\_\_\_\_

• Are you experiencing any difficulty with access to prescribed medications?  Yes  No  
If yes, please describe the difficulties: \_\_\_\_\_

MEDICATION	LENGTH OF THERAPY	DOSING	PRESCRIBER NAME

## PAST MEDICATIONS

List past medications that the patient has taken for Duchenne muscular dystrophy as well as other conditions, if applicable.

MEDICATION	LENGTH OF THERAPY	DOSING	PRESCRIBER NAME

## OBSERVATIONS

Record changes in the patient's weight and abilities here. Share this information with your doctor regularly.

SIGN OR SYMPTOM	BASELINE DATE:	DATE:	DATE:
Weight	Baseline Weight:	Weight: Adjust Dose: <input type="radio"/> Yes <input type="radio"/> No	Weight: Adjust Dose: <input type="radio"/> Yes <input type="radio"/> No
Energy/Activity level	<input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor	<input type="radio"/> Better <input type="radio"/> Worse <input type="radio"/> No Change	<input type="radio"/> Better <input type="radio"/> Worse <input type="radio"/> No Change
Ability to walk	<input type="radio"/> Better <input type="radio"/> Worse <input type="radio"/> No Change	<input type="radio"/> Better <input type="radio"/> Worse <input type="radio"/> No Change	<input type="radio"/> Better <input type="radio"/> Worse <input type="radio"/> No Change
Rising from floor	<input type="radio"/> Better <input type="radio"/> Worse <input type="radio"/> No Change	<input type="radio"/> Better <input type="radio"/> Worse <input type="radio"/> No Change	<input type="radio"/> Better <input type="radio"/> Worse <input type="radio"/> No Change
Use of arms/hands	<input type="radio"/> Better <input type="radio"/> Worse <input type="radio"/> No Change	<input type="radio"/> Better <input type="radio"/> Worse <input type="radio"/> No Change	<input type="radio"/> Better <input type="radio"/> Worse <input type="radio"/> No Change
Breathing function	<input type="radio"/> Better <input type="radio"/> Worse <input type="radio"/> No Change	<input type="radio"/> Better <input type="radio"/> Worse <input type="radio"/> No Change	<input type="radio"/> Better <input type="radio"/> Worse <input type="radio"/> No Change
Mental focus	<input type="radio"/> Better <input type="radio"/> Worse <input type="radio"/> No Change	<input type="radio"/> Better <input type="radio"/> Worse <input type="radio"/> No Change	<input type="radio"/> Better <input type="radio"/> Worse <input type="radio"/> No Change
Behavioral issues	<input type="radio"/> Better <input type="radio"/> Worse <input type="radio"/> No Change	<input type="radio"/> Better <input type="radio"/> Worse <input type="radio"/> No Change	<input type="radio"/> Better <input type="radio"/> Worse <input type="radio"/> No Change

Record any additional observations or details, questions, or concerns you may have regarding the patient's medications or abilities here:

\_\_\_\_\_

\_\_\_\_\_

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## QUESTIONS to help your doctor

Have you received any vaccinations since your last visit?  Yes  No

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Have there been any health status changes since your last visit? Please describe.

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Have you received any unrelated treatment from other healthcare providers since your last visit? Please describe.

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## ADDITIONAL QUESTIONS

Record any additional questions you may have—and your doctor's answers here:

YOUR QUESTION	DOCTOR'S ANSWER
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## IMPORTANT INFORMATION

### INSURANCE

INSURANCE COMPANY		NAME OF INSURED	
TELEPHONE		1ST POLICY NO.	
2ND INSURANCE COMPANY		2ND POLICY NO.	

### PATIENT CARE TEAM

TEAM MEMBER	NAME	TELEPHONE
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