

Making an Informed Medical Decision

Begin the process by listing your symptoms and the limitations they place on your activities...

■ I HAVE THE FOLLOWING SYMPTOMS: Check your symptoms and describe their severity.

	None	Mild	Severe
<input type="checkbox"/> Pain in my lower back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pain in my () right or () left leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pain in both legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Numbness in my () right or () left leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Numbness in both legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Weakness in my () legs or () feet.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Weakness in () one foot or () both feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<input type="checkbox"/> Pain in my () upper back or () neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pain in my () right or () left arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pain in both arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Numbness in my () right or () left arm.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Numbness in both arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Weakness in my () arms or () hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<input type="checkbox"/> Problems with () bowel or () bladder control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

■ BECAUSE OF MY SYMPTOMS, I CAN NO LONGER DO THE FOLLOWING THINGS:

List those areas where you feel you are limited in performing everyday activities. Also list those limitations which reduce your enjoyment of life in general. List them in their order of importance to you.

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

Share this sheet with Dr. Herz during your initial visit. He will use this information to help diagnose your condition and then to provide you with appropriate treatment options.

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Use this sheet to help determine which treatment options are available to you and what you hope to achieve through the course of treatment you eventually choose.

■ MY CONDITION HAS BEEN DIAGNOSED AS: _____

■ MY TREATMENT OPTIONS ARE:

Ask your doctor(s) to help you develop a list of treatment options which are available to you. Be sure to include the risks and benefits of each.

OPTION 1: _____ **RISKS:** _____

BENEFITS: _____

OPTION 2: _____ **RISKS:** _____

BENEFITS: _____

OPTION 3: _____ **RISKS:** _____

BENEFITS: _____

OPTION 4: _____ **RISKS:** _____

BENEFITS: _____

■ THE BEST TREATMENT OPTION FOR ME IS: _____

■ FOLLOWING MY TREATMENT, MY EXPECTATIONS ARE:

Make a list of what you hope to achieve through your course of treatment. Ask your health care provider if these expectations are realistic.

1. _____

2. _____

3. _____

4. _____