**Pinckneyville Community Hospital**
*Leading the way to a healthier tomorrow.*

Patient Name: ______________________________

Date: ______________________________

**The intent of this tool is to provide you with questions that you may want to ask your healthcare provider.*

# PATIENT QUESTIONNAIRE

**MY TOP QUESTIONS (Please Circle Three):**

What is my diagnosis? ______________________________

Will I need any more tests? What are the results of tests that I have not been informed of? ______________________________

What happens if I choose to not have treatment? ______________________________

What are my treatment options? ______________________________

How soon do I need to make a decision about treatment? ______________________________

What are my new medications? Are there any side effects? ______________________________

What is the outlook for my future (prognosis)? ______________________________

Will I need special help at home? ______________________________

My preferences related to my treatment/visit/stay are: ______________________________

Additional questions/needs: ______________________________

If you have questions or concerns regarding the cost of your treatment, please contact Financial Counseling at 618-357-5906

*This tool is a derivative of the AHRQ Question Builder App