Your 28-day takeaway

RLS APPOINTMENT CONVERSATION SHEET

Complete what you can. Bring this page, your 28-day dashboard and your medication list to your appointment.

Name: _____	**Appointment date:** _____
Tracking period: _____ to _____	**Clinician:** _____

1 | MY RLS SYMPTOMS AND THEIR IMPACT

Symptoms (tick all that apply): ☐ Urge to move ☐ Crawling/tingling ☐ Aching/discomfort ☐ Other: _____

Pattern: ☐ Worse while resting ☐ Improved by moving ☐ Worse in evening/night ☐ Other: _____

Areas affected: ☐ Legs ☐ Feet ☐ Arms ☐ Other: _____ Happens about: _____ nights per week

Usually begins at: _____ My worst nights/dates: _____

What has changed? ☐ Earlier onset ☐ More frequent ☐ Spread to other areas ☐ No clear change

Sleep and daily life: ☐ Difficulty falling asleep ☐ Night waking ☐ Daytime fatigue ☐ Other: _____

2 | THREE OBSERVATIONS WORTH DISCUSSING

1. Date(s), what happened and any exceptions: _____

_____

2. Date(s), what happened and any exceptions: _____

_____

3. Date(s), what happened and any exceptions: _____

_____

3 | MEDICATION, HEALTH AND TESTS

Current medicines / supplements (include name, dose and time; attach a list if needed): _____

_____

Missed doses, new medicines, dose changes or suspected side effects: _____

Relevant diagnoses, recent tests or results (including iron studies if available): _____

4 | WHAT SEEMED TO HELP — OR MAKE THINGS WORSE?

Tried: ☐ Movement ☐ Massage ☐ Heat/cold ☐ Compression ☐ Relaxation ☐ Other: _____

Helpful approaches / possible aggravating factors (include timing): _____

_____

5 | MY QUESTIONS AND THE AGREED NEXT STEPS

Questions: ☐ Could my medication affect RLS? ☐ Should further tests be considered? ☐ Treatment options?

Other questions: _____

Agreed next steps / follow-up date: _____

A record is not a diagnosis. A pattern is a question worth discussing, not proof of a cause. **Do not change prescribed treatment without medical guidance.**