My Health Care Journal

Revised:060812

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Introduction

This Health Care Journal is a way to organize all your health related information in one easy document. It allows you to keep all your medical history and current health status in one document. By using this journal, your health care information is easy and ready to share with your medical provider or other health care professionals.

The Health Care Journal is prepared by Molly T. Kennedy, MPA

If you have suggestions on how to improves the Health Care Journal or would like an electronic copy please email mollykennedy1969@gmail.com

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My Health Information

1. Primary Care Doctor: _____

Address: _____

Phone: _____ Email: _____

Have seen since: _____ (Year)

****

2. Dentist: _____

Address: _____

Phone: _____ Email: _____

Have seen since: _____ (Year)

****

3. Specialist: _____

Address: _____

Phone: _____ Email: _____

Have seen since: _____ (Year)

****

4. Specialist: _____

Address: _____

Phone: _____ Email: _____

Have seen since: _____ (Year)

****

5. Specialist: _____

Address: _____

Phone: _____ Email: _____

Have seen since: _____ (Year)

My Health History

Check the ones that apply to you

Visual Problem	□	Hearing Problem	□
Intellectual Disability	□	Speech Problem	□
Respiratory Problem	□	Cardiac Problem	□
GI / Feeding Problem	□	Bowel / Bladder Problem	□
Sleep Problem	□	Skin Problem	□
Behavioral Health	□	Other:	□

Allergies:_____
_____
_____
_____

Birth History: _____
_____
_____
_____

Surgical / Botox: _____
_____
_____
_____
_____

Rehabilitation Services: _____
_____
_____

Social Issues: _____
_____
_____

Behavior Health Issues: _____
_____
_____

Other: _____
_____
_____

My Immunization

Immunization	Date	Date	Date	Reaction if any	Physician
Diphtheria –Tetanus (DT)					
Diphtheria- Pertussis-Tetanus (DPT)					
Tetanus					
Measles-Mumps-Rubella (MMR)					
Measles-Rubella (MR)					
Mumps					
Rubella (3Day Measles)					
Haemophilus Influenza (HIB)					
Hepatitis A					
Hepatitis B					
Varicella (Chicken Pox)					
Rotavirus					
Pneumococcal (Pneeumovac)					
Pneumococcal Conjugate					
Influenza (Flu Shot)					

My Equipment and Assisted Technology

Please indicate which type of equipment you use in your everyday life:

Power Wheelchair	□	Manual Wheelchair	□
Stander	□	Gait Trainer	□
Bath / Shower Equipment	□	Lift/Transfer Equipment	□
Stroller	□	Arm Braces / Splints	□
Back Brace	□	Car Seat	□
Hospital Bed	□	Feeding / Support Chair	□
Commode Equipment	□	Other:	□
Other:	□	Other:	□

Notes:_____
_____
_____
_____

Please list the assistive technology you use in your everyday life:
(Example: glasses, IPad, computer)

Notes:_____
_____
_____
_____

Preparing For My Doctor Appointment

Bring to the Appointment:

Insurance Card	☐
Medical Records	☐
X – Rays	☐
Diagnostic Test Results	☐
Vaccination List	☐
List of All Medication	☐
List of Questions to Ask	☐
Information from other Doctors I See	☐

Why I'm seeing the Doctor Today	Notes
To get a diagnosis for a new symptom	
To confirm a diagnosis	
To get information about a condition	
To report a changes in a condition	
To explore appropriate treatments	
To monitor the success of treatment	
Other:	

How long have the symptoms been going on? _____

What have I tried so far to treat it? _____

What makes it better? _____

What makes it worse? _____

Why I decided to go see the doctor now? _____

My Follow-up from Doctor Appointment


Notes from the appointment:

1. What was discussed with the doctor? _____
_____

2. What is the treatment plan? _____
_____

3. Are there any danger signals I should watch for and report (change in symptoms, medication side effects)_____
_____

4. What follow up tests do I need and when will I know the results? _____
_____

5. When should I call or come back to see the doctor?

   Office Telephone: _____
   Mobile Telephone: _____
   Answering Services: _____
   Pager: _____
   Email: _____

6. Is there anyone else that I should contact? _____
_____

7. Where can I get more information?

   Brochure: _____
   Websites: _____
   Associations (Professional or non profit): _____
   Support Groups: _____
   Telephone Hotline: _____

8. When can I resume my normal activities? _____

Is there addition information about my condition or treatment: _____
_____
_____
_____

My Current Health Status

Date Completed_____

	Never	Sometime	Regularly	All the Time
Pain or Soreness in my Neck / Back				
Pain or Soreness in my Arms				
Pain or Soreness in my Legs				
Low Energy / Tired				
Headaches				
Nausea / Pain in Stomach				
Constipation				
Allergies, Skin Rash,				
Dizziness or Lightheadedness				
Having Stress- Fears – Anxiety				
Moodiness – Temper – Angry Outburst				
Other:				
Other:				

DETERMING WHERE I NEED ASSISTANCE WITH MY HEALT CARE NEEDS

Question	Yes	No	Steps to be Able to do Task
Can I describe my health care needs?			
Are there ways my health care needs affect my day-to-day life?			
Do I know what to do when I get sick?			
Do I know what medications I take and why I take them?			
Do I when to take my medication and possible side effects to report to my doctor?			
Do I know how to get my prescriptions filled and refill?			
Can I make my own medical appointments?			
Do I know how to check in and what to bring to my appointment?			
Can I give information and answer questions at my appointment?			
Do I know how to ask questions at my appointments?			

My Current Medications

Current Medications

Name of Medications	Date Started Taking	For What Reason	Amount / Dose How Often	Doctor who ordered it

Are there any side effects that you have with any of your current medications?

Medication	Side Effects

Medications I have taken in the past that didn't work and why.

Medications	How Long You Took It	Why it didn't work

Family Health History

Medical Conditions	Dad	Mom	Siblings			
Alcoholism						
Anemia						
Anesthesia Problem						
Arthritis						
Asthma						
Birth Defects						
Bleeding Problems						
Cancer, Breast						
Cancer, Colon						
Cancer, Melanoma						
Cancer, Skin						
Cancer, Ovary						
Cancer, Prostate						
Cancer, (not stated)						
Depression						
Diabetes (Type 1) Childhood Onset						
Diabetes (Type 2) Adult Onset						
Eczema						
Epilepsy (seizers)						
Genetic Diseases						
Glaucoma						
Hay Fever (Allergic Rhinities)						
Hearing Problems						
Heart Attack (Coronary Artery Disease)						
High Blood Pressure (Hypertension)						
High Cholesterol (Hyperlipidemia)						
Kidney Diseases						
Lupus (Systemic Lupus Erythematosis)						
Migraine Headaches						
Mitral Valve						
Osteoarthritis						
Osteoporosis						
Rheumatoid Arthritis						
Stroke						
Thyroid Disorders						
Tuberculosis						

Health Care Literacy

What it is? The degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions.

Why is it Important?

- Helps Make More Informed Decisions about Your Health
- Prevent Relapses
- Better Health Outcomes
- Few Complications
- Clear and better communication with your medical provider

Determine Your Health Care Literacy

The following questions will help you determine your level of health care literacy:

	√
Are you able to understand the appointment slips that written for you?	
Are medical forms difficult to understand and to fill out?	
Are you able to read and understand the written materials your health care provide give you?	
Are you able to read and understand the instructions label on the medication bottle?	
Do you have to ask someone else to help you understand the forms and written materials given by your health care providers?	
Do you have to ask someone else to help you understand the instructions label on the medication bottle?	

Health Advocate Checklist

The following are questions to determine your health advocacy skills.

	√
I have a trusted primary care provider?	
I keep some form of personal medical records?	
I understand the cause and treatment of my medical problem?	
I ask questions about recommended test and treatment?	
I speak up when I see problems with my medical care?	
I know my health priorities and preferences?	
I follow the treatment plan recommended by my primary care provider?	
I know my health risks and I am following a plan to manage them?	
I have made a living will and appointed a health care agent?	
I have a personal medication list and understand my medications?	
I take my medication as directed?	
I feel well I can manage minor illnesses at home?	
I understand my health insurance and get the most from it?	
I do a good job of managed my chronic illnesses?	

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