My Health Notebook

JOHNS HOPKINS MEDICINE

This Health Notebook is designed to improve communication between you (or your caregiver) and any healthcare provider. It is intended to be taken to every medical appointment and/or hospital stay. To benefit from this notebook you should follow some basic guidelines.

- ☐ **You (or your caregiver) should fill out as much of this notebook as you can.**
- ☐ **If you cannot fill out a section you should ask for assistance. Doctors, nurses, case managers, and pharmacists will be able to help you.**
- ☐ **Update this notebook whenever your health information changes.**
- ☐ **Any papers you receive from your healthcare provider can be added to this notebook for safekeeping.**

You may print this entire notebook or individual pages at http://www.hopkinsmedicine.org/the_johns_hopkins_hospital/index.html. If you do not have access to a computer or printer, consider visiting your local library or asking your healthcare provider to print the desired pages.

The Women's Board of the Johns Hopkins Hospital provided funding to create this notebook. For more information on the Women's Board of the Johns Hopkins Hospital visit http://womensboard.jhmi.edu/overview.cfm.

In times of stable or good health it is beneficial to document certain aspects of your health and your wishes about your future health care. Taking time when you are in the best of health to make medical decisions will remove stress from friends and loved ones who will try to care for you during a medical crisis.

This notebook chapter guides you to write down important information about your overall health. Consider discussing the items in this section with people you want to make decisions for you if you become unable to make decisions for yourself.

Additional chapters or pages from this book can be printed at: http://www.hopkinsmedicine.org/the_johns_hopkins_hospital/index.html

My Name: _____

My Address: _____

_____

_____

My Phone Number: _____

My Cell Phone Number: _____

Emergency Contact: _____

My Primary Care Provider: _____

Phone Number: _____

My Pharmacy: _____

Phone Number: _____

My Health Insurance Company: _____

_____

My Chronic Health Conditions: _____

_____

_____

My Food or Drug Allergies: _____

_____

_____

_____

My Primary Language: _____

I can do these things without any help (check all that apply):

- ☐ **Walk**
- ☐ **Get dressed (including shoes and socks)**
- ☐ **Take a bath or shower**
- ☐ **Drive (day and night)**
- ☐ **Shop for groceries**
- ☐ **Manage my medications**
- ☐ **Cook a meal**
- ☐ **Clean my house**
- ☐ **Work**

I need caregiver help, a device, or special circumstances to do these things. Include devices such as splints, braces, prosthetics, shower seats, canes, and so on. Check all that apply and explain.

- ☐ **Walk**
- ☐ **Get dressed (including shoes and socks)**
- ☐ **Take a bath or shower**
- ☐ **Drive (day and night)**
- ☐ **Shop for groceries**
- ☐ **Manage my medications**
- ☐ **Cook a meal**
- ☐ **Clean my house**
- ☐ **Work**

_____

_____

If I need to go to a hospital I prefer to go to:

_____

I have had the following shots in the past year (check all that apply):

- ☐ **Pneumonia**
- ☐ **Flu (Influenza)**
- ☐ **Other** _____

In the past year I have: (check all that apply):

- ☐ **Had a fall**
- ☐ **Had difficulty swallowing**
- ☐ **Had problems with my vision**
- ☐ **Had problems with my hearing**
- ☐ **Lost weight**
- ☐ **Gained weight**
- ☐ **Had feelings of depression**
- ☐ **Had feelings of anxiety**
- ☐ **Had feelings of hopelessness**
- ☐ **Other safety concerns of concern:**

_____

_____

_____

_____

_____

Legal Documents (check all that apply)

___ I have a will

Location: _____

___ I have a written living will

Location: _____

___ I have surrogate decision maker in the event that I cannot make medical decisions for myself.

My surrogate decision maker is:

_____

___ I have a document called a medical power of attorney that names my surrogate decision maker.

Location: _____

NOTE: Keep a copy of your living will and medical power of attorney in this notebook.

Write out your wishes for friends and family in the event that you become unable to make medical decisions.

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Caregiver Information

Caregivers are people who add something to you overall physical, mental, or spiritual well-being. You are your own caregiver and the most important part of your health care team. Everyone who loves you or whom you love is not necessarily a caregiver. Some people will not have the ability to be a consistent and reliable part of your support network. Caregivers need to know and understand what makes you special and what special needs you may have.

Caregivers you may have:

- ☐ **Supportive family members or friends**
- ☐ **Primary Care Physician (PCP)**
- ☐ **Specialty Care Physicians**
- ☐ **Nurses**
- ☐ **Therapists**
- ☐ **Dieticians**
- ☐ **Chiropractics**
- ☐ **Case Managers**
- ☐ **Home Health Aides**

Non-caregivers will include:

- ☐ **Family members or friends who are not supportive**
- ☐ **Family members or friends who are not available**

My Family and Friend Caregivers

Name _____

Phone number _____

Address _____

_____

Name _____

Phone number _____

Address _____

_____

Name _____

Phone number _____

Address _____

_____

Name _____

Phone number _____

Address _____

_____

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My Family and Friend Caregivers

Name _____

Phone number _____

Address _____

_____

Name _____

Phone number _____

Address _____

_____

Name _____

Phone number _____

Address _____

_____

Name _____

Phone number _____

Address _____

_____

Name _____

Phone number _____

Address _____

_____

My Primary Care Physician

Name _____

Phone number _____

Address _____

_____

My Case Manager (if applicable)

Name _____

Phone number _____

My Specialty Care Providers (Cardiologist, Rheumatologist, Oncologists, etc…)

Name _____

Specialty Area _____

Phone Number _____

Name _____

Specialty Area _____

Phone Number _____

Name _____

Specialty Area _____

Phone Number _____

Other Healthcare Providers I see (Therapists, Dieticians, Chiropractics, Homeopathies, etc…),

Name _____
Specialty Area _____
Phone number _____

Name _____
Specialty Area _____
Phone number _____

Name _____
Specialty Area _____
Phone number _____

Name _____
Specialty Area _____
Phone number _____

Name _____
Specialty Area _____
Phone number _____

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Managing your medication can be very confusing. Not managing your medication properly can make your health issues worsen and can lead to unnecessary hospital stays. This chapter is designed to assist you in tracking your medication names, how often you should take your medication, and why you are taking your medication.

It is important to remember that medications include:

- ☐ **Medications prescribed by your doctor**
- ☐ **Medications you get from the store (over-the-counter medication)**
- ☐ **Holistic medication (herbals and vitamins)**
- ☐ **Medications you take daily or regularly**
- ☐ **Medications you only take when you need them**
- ☐ **Medications you share with your spouse, family members, or friends**

UPDATE THIS LIST EVERY TIME YOUR MEDICATION CHANGES!

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Medicines

Medicine Name (generic and brand)	How much do I take? (Dosage)	When do I take this medication		Why do I take this medicine?
		__Breakfast __ Lunch __ Supper	__ Bedtime __ Only as needed	
		__Breakfast __ Lunch __ Supper	__ Bedtime __ Only as needed	
		__Breakfast __ Lunch __ Supper	__ Bedtime __ Only as needed	
		__Breakfast __ Lunch __ Supper	__ Bedtime __ Only as needed	
		__Breakfast __ Lunch __ Supper	__ Bedtime __ Only as needed	

Medicines

Medicine Name (generic and brand)	How much do I take? (Dosage)	When do I take this medication		Why do I take this medicine?
		__Breakfast __ Lunch __ Supper	__ Bedtime __ Only as needed	
		__Breakfast __ Lunch __ Supper	__ Bedtime __ Only as needed	
		__Breakfast __ Lunch __ Supper	__ Bedtime __ Only as needed	
		__Breakfast __ Lunch __ Supper	__ Bedtime __ Only as needed	
		__Breakfast __ Lunch __ Supper	__ Bedtime __ Only as needed	

Hospitalization

Although you are managing your health conditions you may sometimes need to go into the hospital. Any hospitalization presents an opportunity for communication breakdowns. You should use this notebook to guide the communication between you and your hospital healthcare team.

While in the hospital you should know:

- ☐ **Your diagnosis**
- ☐ **The name of your attending physician**
- ☐ **The name of your resident physician**
- ☐ **The name of your case manager**
- ☐ **The name of your nurse**
- ☐ **Your surgical procedures**
- ☐ **Other procedures or tests with results**

You may also find it helpful to keep:

- ☐ **A list of questions for your health care team**
- ☐ **A visitor log**
- ☐ **A hospital journal**

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Be Your Own Advocate

This list will guide you in ways you can help yourself and your team.

- ☐ **Things you should have:**
  - **Identification such as a driver's license**
  - **Insurance cards**
  - **A list of your medications**
  - **Your immunization record**
  - **A list of food and/or medication allergies**
  - **Your living will and a medical power of attorney**

- ☐ **Things you should do:**
  - **Ask everyone who enters your room to wash his or her hands or to use the hand gel**
  - **Check your wristband for correct information**
  - **Make sure your hospital doctor knows the name and contact information of you primary care doctor**
  - **Make sure your hospital doctor understands your medical history**
  - **Ask for a list of medications you are given**
  - **Ask why you take each medication**
  - **When leaving the hospital, be sure you know what risks to look for, what to do if there are complications, and what numbers to contact in case of emergency.**
  - **Schedule a follow up appointment**
  - **Ask your doctor if he/she has a safety checklist to follow for any procedure**

My Hospital Stay

Date of Admission: _____

Date of Discharge: _____

Discharge Diagnosis: _____

My description of my discharge diagnosis:

_____

_____

_____

_____

My Attending Physician

Name: _____

Phone Number: _____

My Resident Physician

Name: _____

Phone Number: _____

My Case Manager

Name: _____

Phone Number: _____

My Nurse

Name: _____

Phone Number: _____

Surgical Procedures which occurred during this hospitalization:

Tests and Test Results which occurred during this hospitalization:

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Questions for My Providers

Question	Response

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Care Team Meeting

During my hospital stay, my care team invited me to a team meeting to discuss my care.

Date: _____ **Time** _____

Attendees: _____

_____

_____

_____

_____

_____

_____

The recommendations given to me during this team meeting were:

_____

_____

_____

_____

_____

_____

_____

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Visitor Log

Visitors (care providers, family and friends)

Name	Date/Time	Comments

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Hospital Journal

Date: _____ **Hospital Day:** _____

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Date: _____ **Hospital Day:** _____

Date: _____ **Hospital Day:** _____

Date: _____ **Hospital Day:** _____

Date: _____ **Hospital Day:** _____

Preparing for Discharge

Preparing for discharge from a hospital can be stressful. This chapter will assist you in gathering information you need to have a successful discharge plan.

It is important for you to know:

- ☐ **Your follow up medical appointments**
- ☐ **What conditions indicate a serious medical condition for your diagnosis**
- ☐ **Whom to call for problems or questions**
- ☐ **Your discharge medications (update the medicine portion of this journal!)**
- ☐ **Your recommended diet**
- ☐ **Your recommended physical activity level**
- ☐ **Who will help you at home after discharge**
- ☐ **Equipment you will need at home**
- ☐ **Your rehabilitation plans**

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Medical Appointments After My Hospital Stay

Date: _____ **Time:** _____
Location: _____
Provider: _____
Provider phone number: _____
Reason for appointment: _____

Date: _____ **Time:** _____
Location: _____
Provider: _____
Provider phone number: _____
Reason for appointment: _____

Date: _____ **Time:** _____
Location: _____
Provider: _____
Provider phone number: _____
Reason for appointment: _____

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What conditions or situations should I be aware of after discharge and what should I do about it?

Condition	Action

Important Phone Numbers

Who	When to call?	Number
Primary Care Provider		
Attending from hospital stay		
Nurse from hospital stay		
Case manager		
Pharmacist		

My Diet

After this hospitalization I SHOULD eat:

_____

_____

_____

_____

After this hospitalization I should NOT eat:

_____

_____

_____

_____

My Activities

After this hospitalization I SHOULD do:

_____

_____

_____

_____

After this hospitalization I should NOT do:

_____

_____

_____

_____

My Rehabilitation

After this hospitalization I will expect the following home care or rehabilitation:

_____

_____

_____

_____

_____

_____

_____

_____

My Home Equipment Needs

After this hospitalization I expect the following equipment in my home:

_____

_____

_____

_____

_____

_____

_____

Outpatient Medical Appointments

Each visit to a physician, therapist, or other healthcare provider is important as you manage you health conditions. You should take your Health Notebook with you to each outpatient medical appointment. This chapter provides valuable information for your care provider and guides you in gathering important information.

Important issues to discuss:

- ☐ **Any hospitalizations since last visit (use the "Hospital Stay Chapter" for clarity)**
- ☐ **Stopping or starting any medications since last visit**
- ☐ **Stopping or starting an exercise plan since last visit**
- ☐ **Changes in dietary habits since last visit**
- ☐ **Any other pending medical appointment**
- ☐ **Any questions about specific health concerns**

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Who this appointment is with: _____

Date and time of this visit: _____

Reason for this visit: (describe symptoms such as stomach pain, routine follow-up, prescription refills)

_____

_____

_____

Questions for my provider:

_____

_____

_____

_____

_____

_____

Notes from my appointment:

_____

_____

_____

_____

_____

_____

_____

_____

Who this appointment is with: _____

Date and time of this visit: _____

Reason for this visit: (describe symptoms such as stomach pain, routine follow-up, prescription refills)

_____

_____

_____

Questions for my provider:

_____

_____

_____

_____

_____

_____

Notes from my appointment:

_____

_____

_____

_____

_____

_____

_____

_____

Use this notebook chapter to hold any medical information not already included in the previous sections.

Suggested items for this area:

- ☐ **Health education handouts**
- ☐ **Insurance documents**
- ☐ **Exercise programs**