

caring
for those
you care about

Recording Health History

When it comes to their health, older people often have a lot to juggle—and to remember. They may be taking medications for one or more chronic conditions. They might see several different specialists besides their regular family doctor. And they might undergo a laundry list of routine tests. Many times, trips to the doctor, pharmacy, and lab take up much of their time.

It's easy to forget important information about your health at any age—your last physical, your last health screening. This can be a barrier to getting good care since these are things that doctors need to know to treat you properly and that you need to know to stay healthy. But there's an easy solution—write it down!

If you're helping to care for an older relative, recording his or her health information in one place will make your job much easier. And if you don't have your own written health record, now's the time to start making one.

How To Record Health Information

Recording important health information doesn't have to be hard or take a lot of time. But you do have to be consistent about doing it. The great thing about a

written health record is that all of your health information will be in one place. You won't have to call the doctor's office or look back through old calendars or checkbooks to see when your or your parent's lab test or eye appointment was. And you'll have all the information you need ready to take to your next doctor visit.

There are many ways to record health information. You can download medical history charts from different health Web sites or copy them from books. You can go to a bookstore and buy a health journal. You can use booklets sometimes provided by doctors' offices. Or you can just use a simple notebook. Choose what works for you.

What should you include? Although you don't have to record every cold or sore throat, the more thorough you are, the better. Here is some important information that all health journals should include. You can create a page or several pages for each category, depending on how much information you have. Arrange the information in a way that's easiest for you or your older relative to understand and use. You might want to add more information, depending on your personal situation.

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General Information

This section should go at the beginning and include:

- Your name or the name of your older relative;
- Address;
- Telephone number;
- Birth date;
- Social Security number;
- Family doctor's name and telephone number;
- Name of health insurance company, member number, and telephone number;
- Medicare and/or Medicaid number, if applicable;
- Pharmacy name and telephone number;
- Emergency contact name and telephone number;
- Nearest hospital name and telephone number;
- Blood type;
- Allergies to drugs, foods, bees, etc.;
- Special conditions, such as being diabetic, epileptic, or having a pacemaker;
- Whether you have a living will or health care proxy.

Health Care Providers

In this section, list all health care providers, their specialty, their telephone number, and the condition they are treating. Include home care providers and any others such as acupuncturists, massage therapists, or chiropractors. Here are some examples:

- Primary care physician/Geriatrician;
- Eye doctor;
- Ear, nose, throat specialist;
- Dentist;
- Foot doctor;
- Heart specialist;
- Cancer specialist;
- Allergist;
- Orthopedist (specializes in bone, joint, and muscle problems);
- Gastroenterologist (specializes in diseases of the digestive tract);
- Endocrinologist (specializes in diseases of the glands);
- Neurologist;
- Psychiatrist;
- Psychologist or social worker;
- Physical therapist;
- Nutritionist or dietitian;
- Visiting nurse;
- Home care aide.

Medications

List all prescribed medications, the reason they were prescribed, and the doctors who prescribed them. Include the start date and dosage. Any vitamins, herbs, other supplements, or over-the-counter medicines taken regularly also should go here.

Health Conditions

This section should list conditions such as arthritis, osteoporosis, or high blood pressure. Also include any time you were in the hospital, what you were in for, why, and how long.

Exams, Tests, and Screenings

Include dates and results of examinations, tests, and screenings here, including physicals. Record your height, weight, and blood pressure. Jot down when you need to repeat each procedure again after each entry. Be sure to get screened for the following kinds of conditions:

- Cancer;
- Diabetes;
- Osteoporosis;
- Cholesterol;
- Eye and vision problems;
- Dental problems.

Shots

List dates of shots for flu, pneumonia, tetanus, tuberculosis, allergy, and other shots, in this section.

Family Medical History

It's a good idea to include a family medical history as best you can. Write

down the names of family members who have had cancer, heart disease, dementia, mental health problems, diabetes, and other conditions. If you can remember or get the information from relatives, write down how old family members were when they had the condition, and if they are deceased, what the cause of death was.


Questions To Ask The Doctor

Getting good health care depends on good communication, as well as good information. Patients need to understand what doctors, pharmacists, and other health care providers are telling them — and speak up if they don't. Doctors need to address patients' concerns clearly and thoroughly. Jot down some important questions to ask the doctor before your visit. You might want to add to this list:

- What is my problem and what are my treatment options?
- What is the most effective treatment for this problem?
- If medication is prescribed, what are the side effects and how long do I have to take it?
- Do I need tests? What will the tests show and how do I prepare for them?
- Do I need a follow-up visit?

Begin Where You Are

If you haven't kept any kind of organized health records, it might seem overwhelming to try and start now. Don't worry — it's not too late. Just begin where you are. Record the date and reason for the next doctor visit. Keep your record in an easy-to-reach place and add to it.



whenever you go back to the doctor, have a test done, or get a prescription filled.

Once you start a health record, you can go back and try to fill in the sections a little at a time. It's okay if you don't remember every single illness or doctor visit. Write down what you can. Over time, your journal will take shape, and you and your health care providers will be thankful for your efforts.

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