Your Health Journal

Keeping Track of Your Health

Joint Commission RESOURCES

Your Health Journal

The Basics

Name: _____

Height: _____

Weight: _____

Date of birth: _____

Primary doctor: _____

Contact info: _____

Specialist: _____

Contact info: _____

Specialist: _____

Contact info: _____

Specialist: _____

Contact info: _____

Specialist: _____

Contact info: _____

Pharmacy: _____

Contact info: _____

Health insurance: _____

Policy number: _____

Contact info: _____

Vision insurance: _____

Policy number: _____

Contact info: _____

Dental insurance: _____

Policy number: _____

Contact info: _____

Social Security Number: _____

Blood Type: _____

Date of last physical exam: _____

Medication allergies: _____

Your Health Now

Existing Conditions

Write down every SIGNIFICANT ailment or condition that you have RIGHT NOW.

Ailment/Condition	Current treatment or current medication you're taking for it (include name, dosage, and frequency)	Other info (name of specialist, surgery type and date, etc.)

Current Health

✔ Are any specific health conditions/symptoms bothering you? What are the symptoms? When did they start?

✔ Are you on a special or restricted diet?

✔ Are you under medical care? For what?

Current Medications

(Prescribed meds, herbal supplements, vitamins, over-the-counter drugs—everything that you are taking on a regular basis for any reason at all)

Name of medication	Dosage and frequency	Date you began taking it	The reason you're taking it	Prescribing physician (with contact info)	Special instructions (e.g., take with liquid or food)

Current Medical Symptoms

Context and length of illness can often be important clues, and many patients don't think to really record when things start and how they feel.

Date	Description of symptoms (include timing, duration, location, intensity, and provoking events)	Action

Vital Statistics/Lab Numbers

These numbers are an important part of understanding your overall health. Ask your doctor to help you keep track of them.

Date	Ht	Wt	Blood Pres	Heart Rate	HDL	LDL	Total Chol	Trig	Blood Sugar	CRP	HCT

Ht, height; wt, weight; Blood Pres, blood pressure; HDL, high-density lipoprotein; LDL, low-density lipoprotein; Total Chol, total cholesterol; Trig, triglycerides; CRP, C-reactive protein; HCT, hematocrit.

Your Health History

Immunizations

Fill in date received and any followup needed.

Tetanus, Diphtheria (td): _____

Influenza (Flu shot): _____

Hepatitis B: _____

Hepatitis A: _____

Measles, Mumps, Rubella: _____

Meningococcus (Meningitis): _____

Chicken Pox: _____

Pneumonia (Pneumococcal): _____

TB Screen: _____

Other: _____

Major Illnesses

Date	Illness Type	Treatment

Hospitalizations

Date	Reason	Treatment

Surgeries/Procedures

Date	Type	Outcome

Chronic Diseases

Type	When diagnosed	Treatment	Current treatment

Allergies/reactions (*e.g.*, medications, latex):

_____

_____

Physical limitations (*e.g.*, corrected vision, hearing aid, arthritis):

_____

_____

Your Family History

Relevant Family Health History

List the significant ailments and conditions experienced by family members and relatives, back to your grandparents, that your physician feels are a GENETIC CONCERN. Include your spouse, but the rest of the list should be blood relatives.

Relative (how related to you)	Condition or ailment	Age (or date of death and age attained)	How it was treated	If deceased, did it cause or seriously contribute to death?

Keeping Up with Your Health

Health Exams and Screenings

Fill in the date that the test is performed and the results. Make several copies of the form so you can use it for several years.

	Date	Results
Urinalysis		
Eye exam		
Blood pressure		
Cholesterol		
Depression		
STDs		
Colon exam		
Skin exam		
Mammogram		
Pelvic exam		
Pap test		
Testicular exam		

In Case of Emergency (ICE)

Who should be called in case of an emergency? Do you have any legal documents or directives about your care?

Main Contact

Name: _____

Relationship: _____

Address: _____

Home phone: _____

Work phone: _____

Cell phone: _____

Secondary Contact

Name: _____

Relationship: _____

Address: _____

Home phone: _____

Work phone: _____

Cell phone: _____

Organ Donor Yes ____ No ____

Living Will Yes ____ No ____

Location: _____

Do-Not-Resuscitate Order Yes ____ No ____

Location: _____

Health care Proxy Yes ____ No ____

Location: _____

Contact: _____

Medical Power of Attorney Yes ____ No ____

Location: _____

Contact: _____