

My Health Book



The Medicare QIO for Louisiana
(Formerly Louisiana Health Care Review)

This material was produced by eQHealth Solutions (formerly Louisiana Health Care Review), the Medicare Quality Improvement Organization for Louisiana, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. LA9SoW5E110-2259

Important Contacts & Phone Numbers

This section provides space to record frequently called phone numbers, as well as a detailed list of Community Support Services numbers.

My Personal Health Record

This section provides space to record frequently needed personal information, insurance, diagnoses and physician information all in one convenient place.

Personal Health Record

Name	
Address	City, State, Zip
Phone	Alt. Phone

Date of Birth: _____ / _____ / _____
Month Day Year

Emergency Contact Information

Name	Relation
Phone	Alt. Phone

Advance Directives

Living Will: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please place a copy in binder.)	Health Care Power of Attorney: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please place a copy in binder.)
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Health Insurance

Primary Insurance	Secondary Insurance
Policy No.	Policy No.
Member No.	Member No.

Primary Care Physician

Name	Phone
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Family History *(Check all that apply)*

- Diabetes
- Depression
- Asthma
- Alcohol abuse
- High blood pressure
- Dementia/Alzheimer's
- Stroke
- Heart disease
- Cancer *(type)* _____
- Other *(describe)* _____

Personal Habits

- Currently smoke: Cigarettes Cigars Pipe
 _____ pack(s) per day, for _____ years
- Stopped smoking, (if less than 1 yr.) _____ # months , (if more than 1 yr.) _____ # years
- Drink alcohol, approximately _____ drinks per day
- Exercise, approximately _____ minutes, _____ days per week

Hobbies: _____

Allergies: _____

Diagnoses:

- Heart Attack (AMI) - Date: _____ Heart Failure (CHF) - Date : _____
- Diabetes - Date: _____ Emphysema/COPD - Date: _____
- Other: _____ Date: _____
- Other: _____ Date: _____
- Other: _____ Date: _____

Specialists:

- Cardiologist (heart) Name : _____ Phone: _____
- Pulmonologist (lung) Name: _____ Phone: _____
- Oncologist (blood/cancer) Name: _____ Phone: _____
- Endocrinologist (diabetes) Name: _____ Phone: _____
- Other (type) _____ Name: _____
Phone: _____
- Other (type) _____ Name: _____
Phone: _____

My Plan of Care

This section provides you with a place to record directions from your doctors and warning signs you should watch out for.

My Plan of Care

DIET:

ACTIVITY:

THINGS TO AVOID:

WARNING SIGNS (*When to call the doctor*):

THINGS TO DO:

OTHER INSTRUCTIONS:

My Medicines

During your care, you will often be asked what medicines you are taking. Use this section to write down your medicines as well as other information, such as the name of your pharmacy, your prescribing doctor and the dates you started and stopped medication.

If you stop taking a medication, cross it off the list. If the dose or instructions for a medication change, cross off the original/old information and use a new box to record the new dose/instructions. These steps help to keep your list up to date.

Remember to take this record with you to your appointments so your health care providers have a current list of your medicines.

Medicines

Medicines				
Medicine Name	Dose	How Often	Start Date	Stop Date
<i>Reason:</i>		<i>Side effects:</i>		
<i>Reason:</i>		<i>Side effects:</i>		
<i>Reason:</i>		<i>Side effects:</i>		
<i>Reason:</i>		<i>Side effects:</i>		
<i>Reason:</i>		<i>Side effects:</i>		
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<i>Reason:</i>		<i>Side effects:</i>		
<i>Reason:</i>		<i>Side effects:</i>		
<i>Reason:</i>		<i>Side effects:</i>		

My Numbers

This section provides pages where you can record results of lab tests, monitoring of your weight, blood pressure, etc. and/or other tests you have had.

TEST RESULT

Frequent Testing

BLOOD PRESSURE

Date/ Results		Date/ Results		Date/ Results		Date/ Results	
Date/ Results		Date/ Results		Date/ Results		Date/ Results	

WEIGHT

Date/ Results		Date/ Results		Date/ Results		Date/ Results	
Date/ Results		Date/ Results		Date/ Results		Date/ Results	

OTHER _____

Date/ Results		Date/ Results		Date/ Results		Date/ Results	
Date/ Results		Date/ Results		Date/ Results		Date/ Results	

Screening Tests

COLORECTAL SCREENING

Date		Results		Date		Results	
------	--	---------	--	------	--	---------	--

DEPRESSION SCREENING

Date		Results		Date		Results	
------	--	---------	--	------	--	---------	--

MAMMOGRAM

Date		Results		Date		Results	
------	--	---------	--	------	--	---------	--

PROSTATE PSA

Date		Results		Date		Results	
------	--	---------	--	------	--	---------	--

PAP TEST/PELVIC EXAM

Date		Results		Date		Results	
------	--	---------	--	------	--	---------	--

OTHER _____

BONE DENSITY

Date		Results		Date		Results	
------	--	---------	--	------	--	---------	--

OTHER _____

Immunizations

<input type="checkbox"/> FLU (Annually)	(Date) _____	<input type="checkbox"/> PNEUMONIA (Every 5 yrs.)	(Date) _____	<input type="checkbox"/> OTHER _____	(Date) _____
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Education

This section is for educational materials to help you better understand your diagnosis and do the things that will help you live better and be healthier.

My Medical Visits & Appointments

This section provides you with blank appointment sheets to record your doctor and hospital visits. Use this as both a reminder and as a convenient record to share with your health care providers.

MEDICAL VISITS

Doctor Visits

Date:	Name	Specialty
Reason:		
Plan of Care (<i>What did the doctor say?</i>)		
Were new medicines ordered? If so, add to medicine list.		Follow-up appointment needed? Date?

Date:	Name	Specialty
Reason:		
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Were new medicines ordered? If so, add to medicine list.		Follow-up appointment needed? Date?

MEDICAL VISITS

Hospital Visits

Date:	Hospital Name/Location:		
Reason:			
What treatments did I have?		What were the results?	
Any new diagnosis or concern? If so, describe and add to diagnosis list.			
Were new medicines ordered? If so, add to medicine list.		Follow-up appointment needed? Date?	

Date:	Hospital Name/Location:		
Reason:			
What treatments did I have?		What were the results?	
Any new diagnosis or concern? If so, describe and add to diagnosis list.			
Were new medicines ordered? If so, add to medicine list.		Follow-up appointment needed? Date?	

Date:	Hospital Name/Location:		
Reason:			
What treatments did I have?		What were the results?	
Any new diagnosis or concern? If so, describe and add to diagnosis list.			
Were new medicines ordered? If so, add to medicine list.		Follow-up appointment needed? Date?	

Notes

Use this section to record any additional information about your treatment.

