

Taking Charge of Your Medical Care

Member Handout

“Taking charge of your medical care,” was prepared to help you learn to take an active role in your medical care, to improve your communication with your Doctor and to make sure you give and get the information you need to make wise decisions regarding your health.

What’s at stake is something very important – your well being!

Questions to ask yourself about your current situation:

- Do you have a complete, current list of all of the medications you take, including over-the counter medications, supplements, herbal remedies and laxatives, and do you carry it with you?
- Do you know what your weight and blood pressure were 2 years ago, and if they have changed?
- Do you prepare a written list of questions for the doctor before each visit and write down the responses?
- If you receive a statement from your insurance provider, denying coverage of a procedure months ago, could you find information about the appointment they are referring to?

If you answered “no” to any of those questions, this lesson is for you.

One of the first steps in taking control of your own health care is to create your own record of your medical history and your medical care. Attached are forms that will help you create your own Medical Care Records:

- Health Information Form
- Exams and tests/ Medications
- Medical Care Record sheet
- My Health and Family History
- Medical Expenses Record
- My Appointment Planner

These are also available online at: <http://extension.oregonstate.edu/washington/>

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Taking Charge of Your Medical Care: Health Information Form

Oregon Family and Community Educators (FCE)

A. IDENTIFICATION

Name (Last)		(First)		(Middle)	
Maiden Name					
Primary Address					
City	State	Zip Code	Country		
Alternate Address					
City	State	Zip Code	Country		
Home Phone		Work Phone			
Cell Phone		Email Address			
Date of Birth		<input type="checkbox"/> Male	<input type="checkbox"/> Female		
Height	Weight	Eye Color	Hair Color		
Ethnicity/Race	Organ Donor <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthmarks/Scars			
Blood/RH Type		Special Conditions	Marital Status		

B. EMERGENCY CONTACTS

<i>In Case of Emergency, Notify: Primary Contact</i>					
Name (Last)		(First)		(Middle)	
(Relationship)					
Address					
City	State	Zip Code	Country		
Home Phone		Work Phone			
Cell Phone		Email Address			
<i>In Case of Emergency, Notify: Secondary Contact</i>					
Name (Last)		(First)		(Middle)	
(Relationship)					
Address					
City	State	Zip Code	Country		
Home Phone		Work Phone			
Cell Phone		E-mail Address			

<i>In Case of Emergency, Notify: Medical Contact</i>	
Physician (<i>Indicate Specialty</i>)	
Phone	
Dentist	Phone
Pharmacy	Phone
Primary Health Insurance Carrier	Policy Number
Secondary Health Insurance Carrier	Policy Number

C. LEGAL DOCUMENTS/MEDICAL DIRECTIVES

<input type="checkbox"/> Living Will	<input type="checkbox"/> Durable Power of Attorney for Healthcare		
<input type="checkbox"/> Power of Attorney	<input type="checkbox"/> Advanced Medical Directives		
Document Location (Physical Location)			
Location Name (for example, Bank of America)			
Address			
City	State	Zip Code	
Legal Representative (Name of person who you have assigned legal authority)			
Address			
City	State	Zip Code	Country
Contact Information			
Home Phone		Cell Phone	
Pager		Email Address	
Work E-mail Address		Work Phone	
Date Filed		State Where Registered	

Name: _____

Exams and Tests

Use this form to track your test results.

Exams and Tests	2007	2008	2009	2010	2011
Height and Weight					
Blood Pressure (Desirable: Lower than 120/80)					
Cholesterol (Overall: Lower than 200 is desirable; HDL: 60 or Higher. LDL: 129 or Lower.)					
Blood Sugar					
Pap Smear/Pelvic Exam					
Breast Exam/Mammogram					
Other Tests					
Vision check-up and procedures					
Dental check-up and procedures					

Medications: prescriptions, over the counter medications, supplements and natural remedies.

Date prescribed	Name of my medicine?	How much do I take?	When do I take it?	What do I take it for?	Refills
	XXXX EXAMPLE	1 Tablet 400 mg	3 times a day after meals.	Arthritis	2

(Carry a copy of this Medications information with you.)

Personal Health History

Include significant health problems or events you can remember since childhood. Try to describe the specific problem you had rather than just saying “allergic to penicillin.” Did it make you nauseated? Give you a rash? If you don’t know all the details, you may be able to recover some of them from past medical records.

Serious illnesses

Surgeries

Pregnancies

Past medications

Blood donations and transfusions

Accidents, injuries, emergency care

Mental health: problems, medications,

Alternative and complementary therapies
(e.g., massage, acupuncture)

Family Health History.

Write down what you know about the health history of your immediate family members, including conditions they have and cause of death, if applicable. Pay special attention to conditions that may have a genetic component, such as breast cancer, high blood pressure and neurological illnesses such as Parkinson’s disease and manic depression. This information can be important in helping you and your doctor plan your future health care.

Mother

Father

Siblings

Maternal grandmother

Maternal grandfather

Paternal grandmother

Paternal grandfather

Medical Expense Payment Record For Insurance

Insurance Claim Office Address & Phone Number

Patient Name: _____

Deductible Amt: _____

Policy Number: _____

Date: _____

Date	Provider Name/Address/Phone	Type of Service	Statement and/or Patient ID	Amount of Charge	Ins. filed by provider or patient?	Ins. Paid Date & Amount	Patient Paid Date & Amount	Acct. Closed Y or N	Notes and Comments

Medical Expense Payment Record For Medicare

Insurance Claim Office Address & Phone Number

Patient Name: _____

Deductible Amt: _____

Policy Number: _____

Date: _____

Date	Provider Name/Address/Phone	Type of Service	Statement and/or Patient ID	Amount of Charge	Medicare Approved Amount	Medicare Pd Date & Amount	Medigap Pd Date & Amount	Balance Owed	Patient Pd Date & Amount	Acct Closed Y or N	Notes and Comments

My Appointment Planner

Compete prior to visit

Compete during visit

THINGS TO TELL MY DOCTOR:

Purpose of Visit: (List your concerns and symptoms, starting with the most important ones)

1. _____ 3. _____

2. _____ 4. _____

What symptoms or conditions have changed since my last visit? _____

How am I currently treating my symptoms or conditions? _____

What else is happening in my life? (sleep problems, alcohol use, emotional stress, moved, death of a loved one, new activities, etc.)

MY QUESTIONS: (things to ask in priority order)

1. _____ 3. _____

2. _____ 4. _____

MY DOCTOR'S RECOMMENDATIONS: (things to understand and do)

New/changed medications: (name and dosage-continue on the back of this sheet if necessary)

Treatments: (e.g., appointments with other providers, exercise, heat/ice for injuries, self-care, etc.—continue on the back of this sheet if necessary)

FOLLOW-UP / NEXT APPOINTMENT: _____