



# Personal Medical Journal



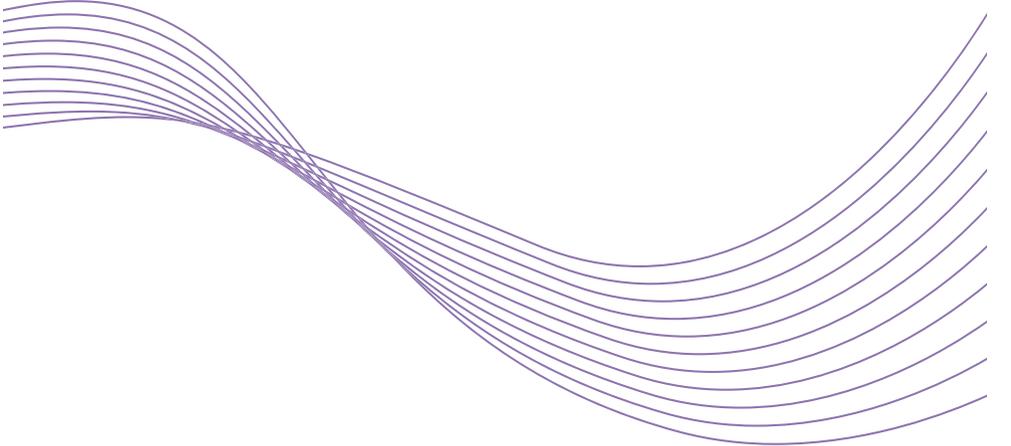
**NPSF**

National Patient Safety Foundation®



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The personal medical journal was designed to help you keep track of your past and present medical care. You are encouraged to write in the journal and bring it to appointments. You can even bring it during a hospital stay. Share your journal with your doctors, nurses and healthcare team. Using your journal can help keep you involved, informed and invested in your healthcare.

As you track your medical history, remember that you play a key role on the healthcare team. You will work closely with your healthcare team for the best results. Listen carefully and use open and honest communication. If you don't understand something, don't be afraid to ask questions.

### **This Personal Medical Journal Belongs to**

**Name:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_

**Mobile Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_

### **Emergency Contact Information *(In Case of Emergency)***

**Name:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_

**Mobile Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_



### Primary Care Provider

Name: \_\_\_\_\_

\_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

\_\_\_\_\_

### Insurance Provider:

Name: \_\_\_\_\_

\_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

\_\_\_\_\_

ID#: \_\_\_\_\_

\_\_\_\_\_

### Pharmacy Information:

Name: \_\_\_\_\_

\_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

\_\_\_\_\_

### Important Contact Information of Family and Friends

Name: \_\_\_\_\_

\_\_\_\_\_

Relationship: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_

\_\_\_\_\_

Relationship: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_

\_\_\_\_\_

Relationship: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

\_\_\_\_\_

# Background Information

## Other Important Contacts

Include contact information for your hospital, specialty providers and patient advocate. An advocate is someone you can trust to look after your welfare and help you ask important questions.

Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_



## Vaccinations

NAME	DATE LAST RECEIVED

## Allergies

Food allergies, medication allergies and other allergies.

ALLERGY	REACTION	SEVERITY OF REACTION <i>(mild, moderate, or severe)</i> <i>Is the allergy life threatening?</i>





## Medical History

Past medical surgeries, injuries and hospitalizations

TYPE OF SURGERY, INJURY, REASON FOR HOSPITALIZATION	DATE

**Current Conditions**

High blood pressure, asthma, etc.

CONDITION	DATE DIAGNOSED

**Advance Directives**

Legal documents that state your preferences about medical care.

**Do you have an advance directive?**

Yes | Share a copy with your healthcare team.

My advance directive is located: \_\_\_\_\_  
\_\_\_\_\_

No | If you are not familiar with advance directives or would like further information, talk to your doctor or healthcare team.



**Daily Hospital Diary** | For use while you are in the hospital to record the following:

**DATE:** \_\_\_\_\_

**Your healthcare team (doctor, nurse, therapist)**

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**All medications you received**

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**Procedures/Treatments/Tests**

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**Pain or Discomfort (0 to 10 scale – 0 for no pain 10 for worst possible pain)**

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---

**Questions**

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**Notes**

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**Procedures/Treatments/Tests**

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**Pain or Discomfort (0 to 10 scale – 0 for no pain 10 for worst possible pain)**

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**Questions**

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**Notes**

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## Daily Hospital Diary

**DATE:** \_\_\_\_\_

**Your healthcare team (doctor, nurse, therapist)**

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**All medications you received**

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**Procedures/Treatments/Tests**

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**Pain or Discomfort (0 to 10 scale – 0 for no pain 10 for worst possible pain)**

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**Questions**

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**Notes**

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## Current Conditions

**DATE:** \_\_\_\_\_

The following section is helpful after you have had a test, procedure, surgery or hospital stay. It will help coordinate information about your condition, medications and follow-up appointments.

### Diagnosis (condition)

**Have you reviewed your discharge instructions with your healthcare team?**

Yes       No

**Do you understand what you need to do when you leave the hospital?**

Yes       No

## Medications

Medications you need to start or continue when you go home.

NAME OF MEDICINE	DOSE <i>(amount)</i>	HOW OFTEN AND WHEN? <i>(morning, afternoon, evening)</i>	HOW TO TAKE <i>(with or without food)</i>	REASON FOR TAKING	FOR HOW LONG



## Home Health Care

If you need help after you are discharged from the hospital, your provider will order home health services. This is when a nurse or member of the healthcare team comes to your home to provide medical care.

**Name of Company:** \_\_\_\_\_

**Contact Person:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Reason for Visit:** \_\_\_\_\_

**Name of Company:** \_\_\_\_\_

**Contact Person:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Reason for Visit:** \_\_\_\_\_

**Name of Company:** \_\_\_\_\_

**Contact Person:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Reason for Visit:** \_\_\_\_\_

## Follow-up Appointments

**Date & Time:** \_\_\_\_\_

**Location:** \_\_\_\_\_

**Reason:** \_\_\_\_\_

**Remember to Bring** (*e.g. my medical journal*): \_\_\_\_\_

**Questions:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Date & Time:** \_\_\_\_\_

**Location:** \_\_\_\_\_

**Reason:** \_\_\_\_\_

**Remember to Bring** (*e.g. current medication list*): \_\_\_\_\_

**Questions:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Date & Time:** \_\_\_\_\_

**Location:** \_\_\_\_\_

**Reason:** \_\_\_\_\_

**Remember to Bring** (*e.g. current test results*): \_\_\_\_\_

**Questions:** \_\_\_\_\_

**Phone:** \_\_\_\_\_



### Follow-up on Lab & Test Results

TEST	DATE

### Activity Recommendations

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### Nutrition/Diet

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## **Medical Terms You May Hear in the Hospital or at the Doctor's Office**

**Diagnosis:** *naming of a disease or illness, also known as a condition*

**Discharge:** *when your doctor decides you are healthy enough to leave the hospital*

**Discharge Planning:** *planning that takes place before you leave the hospital*

**Follow-up Visits:** *doctor's office visits that you schedule and go to after leaving the hospital*

**Healthcare Provider:** *a person, like a doctor or a nurse, who provides healthcare*

**Healthcare Team:** *a team of medical persons, like a doctor, nurse or therapist, who provide care for the mind, body and spirit*

**Home Health Care:** *care you receive from a doctor, nurse or therapist in your home after leaving the hospital*

**In-Patient:** *a person who is admitted to the hospital*

**Length of Stay:** *the number of days that a patient remains in the hospital*

**Medication Management:** *knowing which medication(s) you need to take at what time, and why you need to take them*

**Medication Reconciliation:** *the process of comparing which medications you are taking at home to what you are given at the time of admission or entry into a new healthcare setting or level of care*

**Patient/Discharge Advocate:** *a person who assists you in resolving any issues with your care and informing you about your healthcare choices*

**Patient Safety:** *a new healthcare discipline that stresses the importance of the reporting, analysis and prevention of medical error*

**Primary Care Provider:** *a healthcare provider who plans all of your care when you leave the hospital*

**Readmission:** *when a patient returns to the hospital within 30 days of their original discharge date*







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