What Every Senior Needs to Have: A Health History Sheet

Adapted from: *The Gift of Caring: Saving Our Parents from the Perils of Modern Healthcare*

No one wants to think about going to the hospital. But if you find yourself there, be sure you are armed with a simple document called a "*Health History Sheet*." The Health History Sheet is a short form that assembles in one place a person's doctors, medications, medical health history, a "baseline" of cognitive and activity levels. Too often, when an emergency strikes this vital information cannot be easily retrieved. This can result in the lack of a critical understanding of the "whole" patient leading to misdiagnoses or ineffective treatment regimes.

Errors can set an older person on a trajectory of permanent "step downs" that could have been prevented if the health care team had all the relevant information. Baseline details the activities you can do, and your mental status. It informs any healthcare provider of your medical issues and physical functioning *before* you got sick, and the state you hope to return to after you have been treated.

Complete the Health History Sheet and bring it to your health care provider. Have it updated at all of your medical appointments. Carry it with you at all times and make sure that anyone involved in your health care has a copy, including caregivers and family.

The Gift of Caring Health History Sheet is a form with four parts:

Part One lists the senior's doctors, their phone numbers, a family contact person, insurance and ID number.

Part Two lists of current medications. These are divided into the times of day the medication to ensure accuracy of administration. Each medication should have instructions about whether it is to be taken with or without food or other medications.

Each drug should specify how many milligrams and how many tablets should be taken. For some drugs, such as Coumadin, the dose can vary. In these cases, a phone number of the prescribing clinic or pharmacy should be listed next to the drug. Allergies to medications are also noted in this section.

Part Three is the senior's current health: baseline. It is a succinct summary of a patient's personal and medical history. This is best reviewed with the patient's primary care provider to ensure accuracy. It should record a patient's current cognitive and physical status. Vision and hearing problems should be noted, as should other symptoms that trouble the patient on a regular basis (falls, dizziness, low blood pressure, insomnia, depression, etc.) If a senior has been hospitalized, it should include a sentence or two about the reason for hospitalization and how their recovery is going.

Part Four is a table showing a person's "Activities of Daily Living" or "ADL's". This summary of the patient's function is extremely helpful if they have to go to the emergency department or are hospitalized.

Conscientiously filling out your Health History Sheet can make a tremendous difference in your health care management. Keeping it updated, and making sure you and your family understand the essential medical terminology can be a powerful, pro-active strategy to help you age safely and successfully.

A Health History Sheet can be downloaded from our website, www.thegiftofcaring.net, or copied from our book, *The Gift of Caring*.

A fillable copy of the Health History Sheet can be found on the Viva Village website: vivavillage.org/Resources/Useful Information for Seniors