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Health Communication Issues:

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**Remembering Health History**

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# Health History



## What is health history and what does it include?

A record of a person's allergies, medications, illnesses, surgeries, immunizations, medical results and family history.

## Questions you are expected to know:

- Does your grandmother have blood pressure issues?
- What did your urologist read on your most recent ultrasound?
- What is the name and dosage of every medication you take?

### A. Medical Conditions in Your Family

(Father, mother, grandparents, brothers, sisters, aunts, uncles)

Condition	Relative	Age of Onset	Age and Cause of Death
Allergies			
Arthritis			
Bowel Disorder			
Cancer			
Cataracts			
Diabetes			
Glaucoma			
Hearing Problems			
Heart Disease			
High Blood Pressure			
Pneumonia			
Smoker			
Stroke			
Thyroid Problems			
Other			

### B. Your Medical History

Condition	Date Diagnosed	Treatment to Date
Surgeries	Date	Doctor/Hospital/Comments
Blood Type		
Allergies		
Drug Sensitivities		

Family history should include 3 generations: patients (and siblings), parents (and aunts/uncles), and grandparents. And only includes biological family members.

Doctors often recommend knowing cause of death for family members since such information can be a clue for your personal health.

Treatments can include procedures, medications (OTC or not), holistic care, etc.

Most offices don't provide this portion of the paperwork to the patient since the doctor will fill this out online.

Include all information, even if it doesn't seem relevant. Information like allergies or blood type are good to have on file in case of emergencies.



# Why health history?

As someone who attends a lot of medical appointments for various reasons, it is repetitive having to fill out the same paperwork for each provider.

I recognize that when families separate for various reasons, they don't consider exchanging medical information. Having a foster sister, I worry that her health will be impacted since she doesn't have an adequate family history.

This is a big issue with healthcare that is not evolving at the same rate as other advancements in the same sector. I am curious to know why and teach others the implications that our current system brings.

# Why do providers require medical history?

## Pregnancy

If you were to attend a medical appointment pregnant and incorrectly assumed that the doctor knew you were pregnant, medications or treatments could be prescribed that could harm the unborn child.

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## Medication

Failure to mention specific medications and dosages on your medical history can cause detrimental, possibly even fatal effects because mixing some medications can lead to unsafe reactions.

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## Allergies

As most can imagine, forgetting to communicate to a provider that you are allergic to certain medications or treatments can cause more harm than good during treatment.

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# Currently Obtaining Health History

- Upon check-in to any clinical appointment, you are handed a stack of paperwork to fill out that asks questions about your medical history
- Once finished, the paperwork is given to the front staff to be put into the (usually) electronic health record system
- SO WHY DON'T WE CUT THIS STEP OUT COMPLETELY?!

# Ideas for the Future

## **Universal electronic health record system:**

Many hospitals and large health systems have already adopted this process where patients and their providers are able to update health history on their own time.

## **Mayo Clinic:**

Mayo Clinic uses an interconnected health system across all of its campuses to make it easier for patients and providers to work together. (all campuses, all departments)

## **Setbacks:**

- time it would take to transfer this information
- security/privacy issues associated with having all information in one area

## What Providers Can Do

- ★ Communicate better with other providers to prepare for certain patients' appointments
- ★ Provide patients with a list of what they should know to create a sufficient health history record
- ★ Encourage patients to ask questions or take notes for their health history

## What Patients Can Do

- ★ Ask your doctor questions for clarity
- ★ Bring someone along for extra ears or take notes during the appointment
- ★ Keep an updated file of your medical history to print out and bring to each appointment
- ★ Don't be afraid to ask for help



# So why do we need the change?

## To Keep Patients Safe


It is crucial that the provider know the specific information asked for in the medical history paperwork so that they can treat you accordingly and help more than harm. Providers don't have the time or resources to ask every question so they rely on paperwork and records.

## To Improve Patient Outcomes

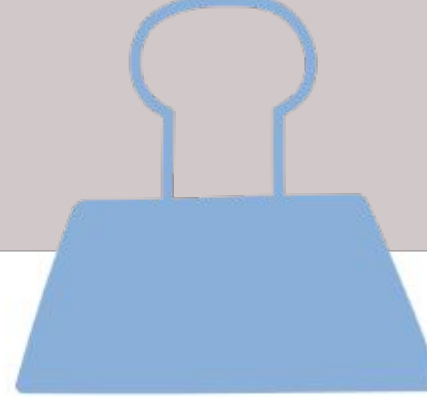
Having adequate health history allows the provider to recognize early signs of disease and create treatment plans that best fit each person. This would make patients healthier, quicker.

## To Make Healthcare as Efficient as Possible

Being able to access all medical history and information in one spot would make providing care more efficient for all. For one, less time would be spent translating medical history information from paper to EHR during check-in.



# What does this mean for healthcare in the long run?

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Less time per visit

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Less visits overall

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More efficient  
preventative care

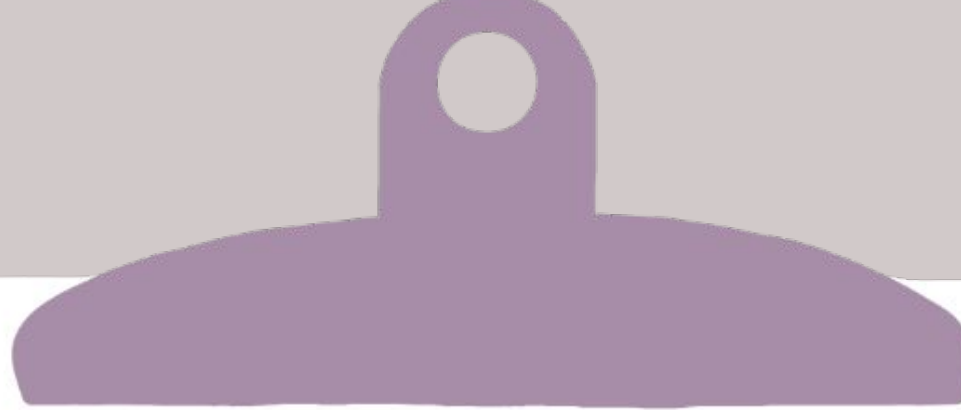


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A healthier  
population :)



# Tips and Tricks I Learned

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- ☐ When gathering health information, beware of metastatic cancer sites
  - ☐ The younger age that a disease develops, the more likely it is due to heredity
  - ☐ While health history is important, lifestyle still plays a major role in health
  - ☐ Ask a provider for a blank copy of their medical history paperwork to get started on your at home file
  - ☐ Talk to your family about family medical history - it may be beneficial to tell them why you are asking such questions
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## Resources

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