Personal Health Record

Rocky Mountains

Jane Cameron

You can get more copies of this Personal Health Record from the
Canadian Down Syndrome Society
811 - 14 Street NW
Calgary, Alberta
CANADA T2N 2A4

You can also download this record from our website
www.cdss.ca
Phone toll-free 1-800-883-5608
Local phone (403) 270-8500
Fax (403) 270-8291

About the Artist

Jane Cameron was born in High River, Alberta in 1949. Jane travelled the world, met many famous people and won many medals and trophies.

Jane Cameron had Down syndrome. Her parents knew that Jane needed much love, care and education, as all children do. They gave her many opportunities to learn and practice her art.

Jane was a great artist. Her artwork and tapestries tell us about her imagination and her love of life.

Jane also liked to swim and bowl and won many medals at Special Olympics.

Jane died in January, 2000. She lived well and did many things. You can learn more about Jane and her artwork on her website at: www.janecameron.com.

Acknowledgements

The Canadian Down Syndrome Society and Ups and Downs (Calgary Down Syndrome Association) thank:

• Persons with Developmental Disabilities, Calgary Region Community Board (Community Capacity Initiatives) for partial funding of this project

• Down Syndrome NSW, Australia, for permission to use some of their materials

• The Jane Cameron Archives of the In-Definite Arts Society, Calgary for permission to use the painting on the front cover of this publication.

Printed 2005

This book belongs to

____

The record is for you to keep.

It has 4 parts.

Part 1 is just for you. You can write about yourself or things that are important to you. You can put in photos. You do not need to show this part to anyone, unless you want to.

Part 2 is to keep information about your life history and your health. It has pages that will tell you about how to stay well. It also has pages where you can write down how much you weigh and (if you are a woman) about your periods. Your care givers, members of your family, or friends can help you fill in these pages, if you like. You can share these pages with people you trust, such as your care givers and your doctors or nurses.

Part 3 is for your doctor or nurse to keep information about your health. It gives them a place to record your tests and medications. They can write down what they want you to do to stay healthy. You can show these pages to all the medical people you see, so that each knows what the others do for you.

They can write down their names, phone numbers and how they help you.

Part 4 has extra pages to copy when a page is filled up.

Part 1 - Just for you

You can write your own stories here, if you want.

You can put in photos or pictures.

Part 2

Part 2 - This part is for you to complete with the help of your family and care givers

This part is for you to complete with the help of your family, care giver or friend. It is yours and you should keep it in a safe place. You can write down information about what you like to do, your health and who helps you. There are also some good health tips.

Other people can make copies of important pages if you say it is "okay".

Please make sure you answer all the questions because your health history is very important. Ask someone to help you to complete the forms and charts because some are hard to do alone.

Take this journal with you to your appointments so that the doctors and other health care people can read it and give you the best medical care.

Information for you

Fill in what you can or ask for help

Name:

____

Man ☐ Woman ☐

Phone: ____

Age: ______________ Date of birth: _____/_____/_____
day month year

Date when this record was started: ______________________________

Things you like to do: please check things you do every week and say how many times each week.

	Activity	How many times?			
☐	Social club	____________	☐	Bowling	____________
☐	Gym	____________	☐	Walking	____________
☐	Music	____________	☐	Cycling	____________
☐	Cooking	____________	☐	Dancing	____________
☐	Basket ball	____________	☐	TV	____________
☐	Crafts	____________	☐	Videos	____________
☐	Movies	____________	☐	DVDs	____________
☐	Exercises	____________	☐	Reading	____________
☐	Swimming	____________	☐	Skiing	____________

Other things you do:

____

____

Do you go to school now? ☐ Yes ☐ No

If yes, name of school:

___

What classes do you take?

___

___

Do you have a job? ☐ Yes ☐ No

If yes, where do you work?

___

What do you do there?

___

___

Do you do volunteer work? ☐ Yes ☐ No

If yes, what do you do?

___

___

Where do you live?

- ☐ At home with my family
- ☐ On my own
- ☐ With other people

Who do you like to spend time with?

____

____

Who do you like to talk to?

____

____

What makes you feel happy?

____

____

Are you a member of any clubs? ☐ Yes ☐ No

Which ones?

____

____

What you do everyday

This page is to record what you do by yourself and what you might need help with. Please complete this list once a year.

There are things we need to do everyday. How do you do them?

If your skills change a lot, it is good to have a record. How you feel affects what you do. If you cannot do things you used to, a health care person should help you find out why.

Date completed: ____________________

	Can do by myself	Can do with help	Someone does it for me
Use the bathroom			
Dressing			
Choose clothes			
Buy clothes			
Wash clothes			
Cook meals			
Buy groceries			
Make plans with friends			
Clean room			
Manage money			
Use public transportation			
Take care of own money			

How do you like to get information?

☐ Hear it

☐ Read it

☐ See it in pictures

Your Medical History

Date: ______________________

Who filled out these pages?

____

These questions are about you

Name ____

Date of birth day______/month_____/year_____ Man ☐ Woman ☐

Health care number ____________________________________

Family Doctor ____________________ Phone ______________

Medical conditions and drug allergies

Do you wear a medical alert? What does it say?

____

____

____

____

____

____

____

____

____

____

____

Past hospitalizations and operations

Date	Hospital	Reason

Drug allergies (describe reaction)

Food allergies or intolerances

Other health concerns

Family Medical History

Your family information helps doctors know how to help you.

Please fill in this medical information about your close family - grandparents, parents, brothers and sisters.

Did anyone have:	Which relative? (i.e. aunt or brother)
Alcoholism	
Arthritis	
Diabetes	
Cancer (what kind)	
Dementia or Alzheimer's	
Depression	
Developmental disability	
Heart disease	
High blood pressure	
High cholesterol	
Mental illness	
Obesity	
Seizures	
Sleep apnea	
Stroke	
Thyroid disease	
Other	

Changes

If someone you love has died, you may feel very sad. It will help people to understand you better if you let them know about this. Please write the names of close family members or friends who have died, as well as any special name you have for them. Write what year they died.

Name: Year:

List of people who help you

Next of kin (such as your parents, brothers or sisters)

Address

____

Phone

____

Guardian (if you have one) ____________________________________

Phone ______________________

Family doctor ____

Phone ______________________

Dentist ____

Phone ______________________

Agencies that help you

Agency ______________________ Phone ______________________

Agency ______________________ Phone ______________________

Care giver ____

Phone ____________________

Care giver ____

Phone ____________________

Friend ____

Phone ____________________

Record of how much you weigh

Write down how much you weigh on the first of each month.

	2005	2006	2007	2008	2009
Jan 1					
Feb 1					
Mar 1					
Apr 1					
May 1					
Jun 1					
Jul 1					
Aug 1					
Sep 1					
Oct 1					
Nov 1					
Dec 1					

For women — a record of your periods

You may want to have someone help you with this. Put a tick mark in the box for each day of your period each month.

Write **N** in box if your period is normal.
Write **C** in the box if you have clots.
Write **P** in the box if you have pain.
Write **F** in the box for flooding.

Day	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1												
2												
3												
4												
5												
6												
7												
8												
9												
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31												

Health

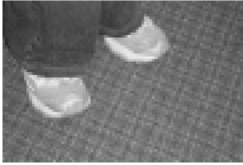
Here are some things to do to stay healthy.

Food. It is important to eat well. Use Canada's Food Guide to help you choose foods to eat. It is often easy to get too heavy and this can lead to other health problems.

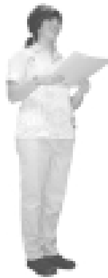
Exercise. Try to exercise 2 or 3 times each week. It will help keep you well. You can go for a walk, go bowling, swim, go to exercise classes, or do something else you like.

Sexuality. You are a sexual person and have the right to know about sex and to have sex, when you are ready. If you need to know more about sex, ask your doctor, nurse, family member or someone you trust. If you have sex, you may make a baby (pregnancy). There are ways to have sex without getting pregnant.Your doctor can help you pick the best way for you. If you have sex, always protect yourself from STDs (Aids and other sex diseases).

Problems when you eat (indigestion or reflux). If you burp a lot, or have pain in your stomach, belly, or throat make sure the doctor knows. Also, make sure you tell your doctor if your bowel movement is very hard or runny. You may need to change what you eat. You can get help to work out what is best for you.



Feet. Make sure you always wear shoes that fit you and support your feet. You need them to be comfy so you can walk well. Shoes that support your feet will make it easier to keep your back, hips and knees strong. You may need to see a foot doctor.



Ears and Eyes. Make sure you have your ears and eyes tested each year.

Skin. It is important to keep your skin healthy too. Look after your skin so that it does not get too dry.

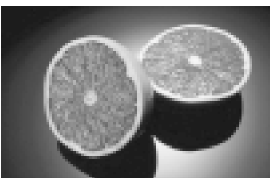
Do not take very hot baths.

If you go to a swimming pool, shower well after the swim. The water in the pool has chemicals in it that can dry out your skin.

Always use sunscreen and a hat outside in the sun.

If your skin is itchy or sore, tell your doctor.

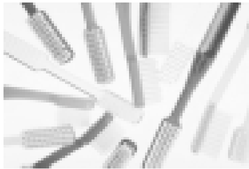
Keep clean. Always wash your hands when you have been to the bathroom and before you eat. Unwashed hands can have germs on them. Germs can make you sick.



Colds. Eat well and try to keep away from anyone with a cold or a sore throat. This will help keep you well. Use a Kleenex to cover your nose and mouth when you cough or sneeze. Then put the Kleenex in the garbage and wash your hands.

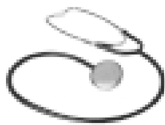
Tiredness. There are many things to check. If you feel extra tired for two weeks ask yourself these questions: Do you eat well? Do you get the sleep you need? Do you get out of your home most days, to get fresh air? Are you able to take some exercise? If you do these things and you are still very tired, you need to tell your doctor.

You may feel tired if you have **depression**. This can also make you feel very sad. It can make you not want to do the things you usually enjoy. Tell your doctor if this happens to you.



Teeth and gums. It is very important to visit a dentist twice a year. Brush your teeth after every meal. This keeps your teeth clean and your gums healthy. Tell your dentist if you have pain in your mouth.

For women. Keep a chart of your periods (see page 2-13). If they happen more often than usual, or if they are late, tell your doctor.



Medical check up. It is important for your doctor to give you a check up each year, even if you feel well.

Abuse. Someone may have hurt you and told you not to tell. Please tell a person you trust if you have been hurt, or if you have been touched in some way that makes you feel bad about yourself. Often your doctor or nurse is a good person to tell. If they don’t listen, tell someone else — until SOMEONE listens.

When you are healthy, you will feel good.

Part 3

Part 3 - For the doctor - List of medications

This section is for the doctors to write down your medications. Ask your doctor to write down your medications and cross out the medications you don't take anymore.

Date reviewed:
(d)____/ (m)____/ (y)____

Drug 1 ______________________
Drug 2 ______________________
Drug 3 ______________________
Drug 4 ______________________

Date reviewed:
(d)____/ (m)____/ (y)____

Drug 1 ______________________
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Medical Instructions

Your doctor may tell you things to do to be healthy. You, your doctor or your care giver can write these instructions here.

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Record of Health Visits

This is a record of your visits to doctors and other health care people.

Date	Who did you see?	What did you find out about your health?

Screening Test Checklist

Your doctor will check these health questions. Sometimes you will have medical tests to make sure you are healthy. Your doctor or nurse can check each box as the test is done and note any unusual results on the next page.

	2005	2006	2007	2008
Blood pressure				
Weight				
Hearing				
Breast / testes				
Mammogram				
Prostate / PR				
Menstrual cycle				
Pap test				
Diet				
Smoking / alcohol / drugs				
Dental				
Exercise				
Mood				
Blood tests:				
Thyroid				
Glucose level				
Fasting lipids				
PSA				
Hepatitus B				
Other				
Immunizations:	Immunizations protect us from disease. Your doctor can tell you what immunizations you need and how to get them.			
Influenza				
Other:				

Test Results

Sometimes doctors find things that need to be checked again.

Date	Result	Action Taken

People who help you to be healthy

	Date	Name	Phone
Audiologist (ears)			
Cardiologist (heart)			
Dentist (teeth)			
Dermatologist (skin)			
Dietician (eating)			
Endocrinologist (hormones)			
E.N.T. (ears, nose, throat)			
Family doctor			
Gynecologist (periods, pregnancy)			
Oncologist (cancer)			
Optometrist (eyes)			
Orthopedic surgeon (bones)			
Physical therapist (muscles)			
Podiatrist (feet)			
Psychiatrist (mood)			
Psychologist (mood)			
Rheumatologist (joints)			
Speech therapist (talking)			
Social worker (counselor)			
Other			

Part 4

Blank pages to copy and use in the future

What you do everyday

This page is to record what you do by yourself and what you might need help with. Please complete this list once a year.

There are things we need to do everyday. How do you do them?

If your skills change a lot, it is good to have a record. How you feel affects what you do. If you cannot do things you used to, a health care person should help you find out why.

P

Date completed: ____

	Can do by myself	Can do with help	Someone does it for me
Use the bathroom			
Dressing			
Choose clothes			
Buy clothes			
Wash clothes			
Cook meals			
Buy groceries			
Make plans with friends			
Clean room			
Manage money			
Use public transportation			
Take care of own money			

How do you like to get information?

☐ Hear it

☐ Read it

☐ See it in pictures

List of people who help you

Next of kin (such as your parents, brothers or sisters)
Address

____

Phone

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Guardian (if you have one) ________________________

Phone ________________________

Family doctor ________________________

Phone ________________________

Dentist ________________________

Phone ________________________

Agencies that help you

Agency ________________________ Phone ________________________

Agency ________________________ Phone ________________________

Care giver ________________________
Phone ________________________

Care giver ________________________
Phone ________________________

Friend ________________________

Phone ________________________

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