

# Sample: About My Health

## 1 My Information

<b>Name</b>		<b>Birthday</b>		<b>I like to be called</b>	
First	Last	Year	Month	Day	<input type="checkbox"/> He <input type="checkbox"/> She <input type="checkbox"/> They

<b>My Address</b>				<b>My phone number</b>	
Apt #	Street	Province	Postal Code		

<b>My health card number</b>	<b>Expiry date:</b>

**I live (check all that apply)**

Alone    With family    With parents    With roommates    Other:  
 With spouse/partner    With friends    In a group home    In supported independent living

## 2 Things I want you to know about me (Note: think about who will be seeing the form when you decide what to include)

<b>My interests and what I like to do</b>	<b>Important people in my life</b>	<b>Difficult life experiences I have had that I want you to know about</b>

## 3 My emergency contact

<b>Name</b>		<b>Relationship to me</b>
First	Last	

<b>Address</b>				<b>Phone number</b>
Apt #	Street	Province	Postal Code	

## 4 Do I have someone who I want to help me make my health care decisions? Yes No

<b>Name</b>		<b>Relationship to me</b>
First	Last	

<b>Address</b>				<b>Phone number</b>
Apt #	Street	Province	Postal Code	

## 5 Is there someone I want to be told about my health care appointments? Yes No

<b>Name</b>		<b>Relationship to me</b>
First	Last	

<b>Address</b>				<b>Phone number</b>
Apt #	Street	Province	Postal Code	

## 6 Important things about my health

### Medical history and conditions

### Things I am allergic to and what happens to me (if known)

## 7 My family doctor (or nurse practitioner)

### Name

First

Last

### Phone number

### Address

Apt #

Street

Province

Postal Code

### Fax number

## 8 My pharmacy

### Name

First

Last

### Phone number

### Address

Apt #

Street

Province

Postal Code

### Fax number

## 9 My medications

### Do I have drug coverage?

Yes

No

### My drugs are paid for

Ontario Disability Support Program (ODSP)

Ontario Drug Benefit (ODB)

Other

I don't know

### How do I take my medications?

Whole

Crushed

Mixed with Food

Other

## 10 How can you make my health care visit better?

### What makes me uncomfortable, scared, or nervous about seeing the doctors and nurses?

### If I am...

Scared/nervous

Uncomfortable/overstimulated

In pain/hurting

Sad

Angry

### I show it by:

### You can help me by:

**Try these to help with things like needles, x-rays, or bloodwork**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Show and tell me what you are doing | <input type="checkbox"/> I like hearing how well I am doing                 | Get me to look away and do it as quickly as you can |
| <input type="checkbox"/> Let me ask questions                | <input type="checkbox"/> Talk me through each step as you do it             |   |
| <input type="checkbox"/> Use numbing cream for needles       | <input type="checkbox"/> Remind and help me count to ten                    | Other:  |
| <input type="checkbox"/> Be quiet so I can concentrate       | <input type="checkbox"/> I like a little something to look forward to after |   |
| <input type="checkbox"/> I like my hand held                 | <input type="checkbox"/> Let me touch the equipment                         |   |
| <input type="checkbox"/> Remind me to take deep breaths      | <input type="checkbox"/> Play music or sing                                 |   |

**Things that you can do to help me understand:**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Look at me when you speak | <input type="checkbox"/> Write it down | <input type="checkbox"/> Let my caregiver or staff explain | <input type="checkbox"/> Speak directly to me first                                  |
| <input type="checkbox"/> Speak slowly              | <input type="checkbox"/> Repeat things | <input type="checkbox"/> Use simple language               | <input type="checkbox"/> Speak louder so I can hear you because I am hard of hearing |
| <input type="checkbox"/> Use pictures              | <input type="checkbox"/> Use gestures  | <input type="checkbox"/> Ask me to repeat it back          |  |

Other

**Things I like at health care visits:**

Empty box for notes on things liked at health care visits.

**Things I don't like at health care visits:**

Empty box for notes on things not liked at health care visits.

**📌 Other helpful information for doctors and nurses**

**Do I have a...**  
*These plans may include information on things you can do to help me calm down or feel better. Ask me or the person supporting me for this information or find it attached.*

<input type="checkbox"/> Health Care Plan	<input type="checkbox"/> Emergency or Crisis Plan	<input type="checkbox"/> Other
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**More information about my health is attached to this form**  Yes  No