Mywell Health

My Health Profile

Learn about, record and routinely update your health information by completing your health profile. The following tables encourage you to explore and think about important factors that impact your health. Your up-to-date health profile will help you participate in health care decisions, advocate for yourself, and navigate your choices with confidence.

Start by gathering your notes, medical letters, medications, vaccination records, and medical reports. Fill in the tables as you are able. Part of this activity will be to seek information from your health professionals, family members, and online sources.

Resource Kit

Click the underlined words in each activity to explore the online resource kit. The resource kit provides definitions and links toresearch-based websites, services, resources, tools, videos, and more!

MywellHealth.info

Write your full name & date completed/updated here:
(It will automatically appear on every page)

Personal & Emergency Information

Tip: Some words might be new to you. Click on the underlined text to open your online resource kit that provides definitions, links to research-based & government websites, services, resources, tools, videos and more.

Personal Information	
Full Name	
Preferred Name/ Goes by	
Pronoun	
Phone	
Email	
Street Address	
City & Postal Code	
Date of Birth (Day, Month, Year)	
Place of Birth	
Personal/ Provincial Health Number (PHN)	
Social Insurance Number (SIN)	
Family Physician & City	
Preferred Language	
Interpreter Name & Phone number	

Emergency Contacts	
First Emergency Contact **Full Name**	
Relationship	
Phone	
Second Emergency Contact **Full Name**	
Relationship	
Phone	
Temporary Substitute Decision-Maker or Substitute Decision-Maker **Full Name**	
Phone	
Power of Attorney (Enduring) **Full Name**	
Phone	
Are you a "Registered' Organ Donor?	
Do you have a Do Not Resuscitate (DNR) or No CPR written order?	
Do you wear a Medic Alert?	

Tip: Have you identified others who can make decisions for you, if you become very ill or unconscious? There is a difference between a temporary substitute decision-maker and substitute decision-maker. Learn about a power of attorney (Enduring). Complete the activity "Choosing a Temporary or Substitute Decision-Maker".

Medications

It is important to know and record all items on your medication list. This includes all medications you take that have been prescribed, as well as, over the counter drugs, vitamins, herbs, supplements, inhalers, allergy medications, pain medications, laxatives, and creams you might be using on a regular or casual basis. All these substances together can cause interactions that can impact your health.

Tip: Check with you pharmacist for an updated lists of all your prescribed and purchased medications. Review this list every year with your physician or nurse practitioner.

Medication List

Make a complete medication list. Include all prescribed medications, over the counter drugs, vitamins, herbs, supplements, inhalers, allergy medications, pain medications, laxatives, and creams you might be using on a regular basis.

Name	Dosage/Amount Taken	Date Started & Reason For Taking

Medication List (2)

Include all prescribed medications, over the counter drugs, vitamins, herbs, supplements, inhalers, allergy medications, pain medications, laxatives, and creams you might be using on a regular basis.

Name	Dosage/Amount Taken	Date Started & Reason For Taking

Substance Use

Alcohol and recreational drug use can impact medications, mood and overall health. It is important to know what and how much you use daily or weekly. This is a question that is asked at a hospital admission or before surgery. Your physician, nurse practitioner, specialist or anyone who prescribes medications to you should have this information.

Alcohol Use

List types of alcohol and number of drinks daily/weekly. Learn more about alcohol use.

Recreational Drug & Cannabis Use

List types of drugs and amount taken daily/weekly. Learn more about recreational drug use. Describe age started and/or stopped. Number of years as a recreational or cannabis user.

Tobacco Use

Amount smoked, vaped or chewed daily/weekly. Learn more about tobacco use. Describe age started and/or stopped. Number of years as a smoker.

Allergies

Allergies to Medications

List all allergies and sensitivities you have to medications. Include all over the counter drugs, vitamins, herbs, supplements, inhalers and creams. Describe your reaction and treatment.

What you are allergic to?	Allergic Reaction	Treatment

Other Allergens

List all allergies you have to other substances; include foods, insect bites , smells and any products (soaps, cleaning agents, perfumes), or substances (latex, plastics). Describe your reaction and treatment.

What you are allergic to?	Allergic Reaction	Treatment

TIp: If you have severe reactions to any medications or substances, such as difficulty breathing, you might want to learn about Medic Alert and or carry an Epi-pen.

Health, Medical & Surgical History

Your health and medical history should include your health conditions, mental illnesses, surgical history, sexual health, emotional health, infectious diseases, vaccination record, family health history, and concerns. The more you know and can share with health professionals, the better they can care for you.

Tip: Learn how to save and share your health profile digitally so that you can access it on your phone during appointments or during an emergency.

General Health	
Blood Type (If known)	
Hearing Any changes or concerns? Do you wear hearing aids?	
Vision Any changes or concerns? Do you wear glasses or contact lenses?	
Emotional Health Describe if you have experienced or concerns with anxiety, depression, suicidal thoughts, sleep changes, mood swings, memory loss, confusion or dementia.	
Mobility Concerns, Falls or Safety Issues Do you have any problems or concerns with your mobility? Do you have weakness, dizziness, or limitted coordination? Have you fallen in the past few months? Do you use any mobility aids/ devices?	
Medical Assistant Devices Do you have any medical assistant devices such as insulin pump, feeding tube, central line, heart pacemaker, or other?	

Health Conditions (Physical and Mental Illnesses)

List all of your physical and mental illnesses. Include chronic pain and other health issues you deal with on a regular basis. Describe how each health condition impacts you physically, mentally, and socially.

Name/ Diagnosis	Year of Onset	How does the condition impact your daily life?

Infectious Diseases

Describe any short-term and long-term effects of these infectious diseases on your health.

Infectious Disease	Date (Month, Year)
Covid-19	
MRSA	
Hepatitis (Type)	

Hospitalizations

List your hospitalizations in the previous 5 years or any significant hospitalization in the past.

Date (Month, Year)	Reason for Hospitalization & Length of Stay

Surgical History

Describe your surgical history by listing the surgery name, reason for the surgery, and any complications or reactions to anesthetics.

Month & Year	Name of Surgeon	Name of Surgery	Description

Family Health History

Describe your family health history (of relatives you are connected to genetically and biologically).

Relationship of Family Member	Describe their health history including health conditions, diagnoses, age of diagnosis, current age, or cause of death.
Mother	
Father	
Siblings	
Children	

Sexual Health

Describe your sexual health concerns and issues as it is impacted by your health conditions, medications, treatments and/or age.

	Describe your sexual health history and currrent concerns
Gender Identity & Sexual Orientation	
Recommended Screening (Mammogram, Testicular, Prostate, Breast, Cervical, other.)	
Sexually Transmitted Infections (STIs)	
Sexual Functioning	
Contraception	
Fertility Issues	
Menopause	
Other	

Emotional Health

Describe your emotional health and how it impacts your daily life.

	Describe the symptoms related to your emotional health, including how frequently they occur and the impact they have on your daily life. List any medications, therapies, and coping strategies you have used
Anxiety	
Depression	
Suicidal Thoughts	
Mood Changes	
Sleep Changes	
Anger Outbursts	
Stress	
Confusion	

Adult Vaccination Record		
Name of Vaccine	**Most Recent Date (Month, Year)**	**Reaction if any?**
Influenza vaccine		
Covid Vaccine		
Last Tetanus vaccine		
Shingles vaccine #1		
Shingles vaccine #2		
Hepatitis vaccine A		
Hepatitis vaccine B		
Human Papillomavirus (HPV)		

Tip: Learn how to set up an account with Health Gateway BC to access your current vaccination record. Learn more about vaccines at Immunize BC..

Notes for My Health Profile

Use the 'Notes for My Health Information' to collect all your thoughts in one place. A place to make quick notes if you do not have all the correct information you need to complete an activity or information table.

Date	A place to record your thoughts, questions, and learning

Notes

Date	A place to record your thoughts, questions, and learning