Guide to Creating Your One Page Medical Summary

That Will Empower You & Help Your Doctor Listen

© 2023 Veronique Mead, MD, MA
Chronic Illness Trauma Studies
All rights reserved.

v. Nov 16, 2023

This is a more detailed how to version of the guide than the one on my blog.

You can download the free companion forms for inserting your own text into a one pager in MS word in the blog post. Or get the kindle version of this pdf. It has fewer pictures, also available from the blog post.

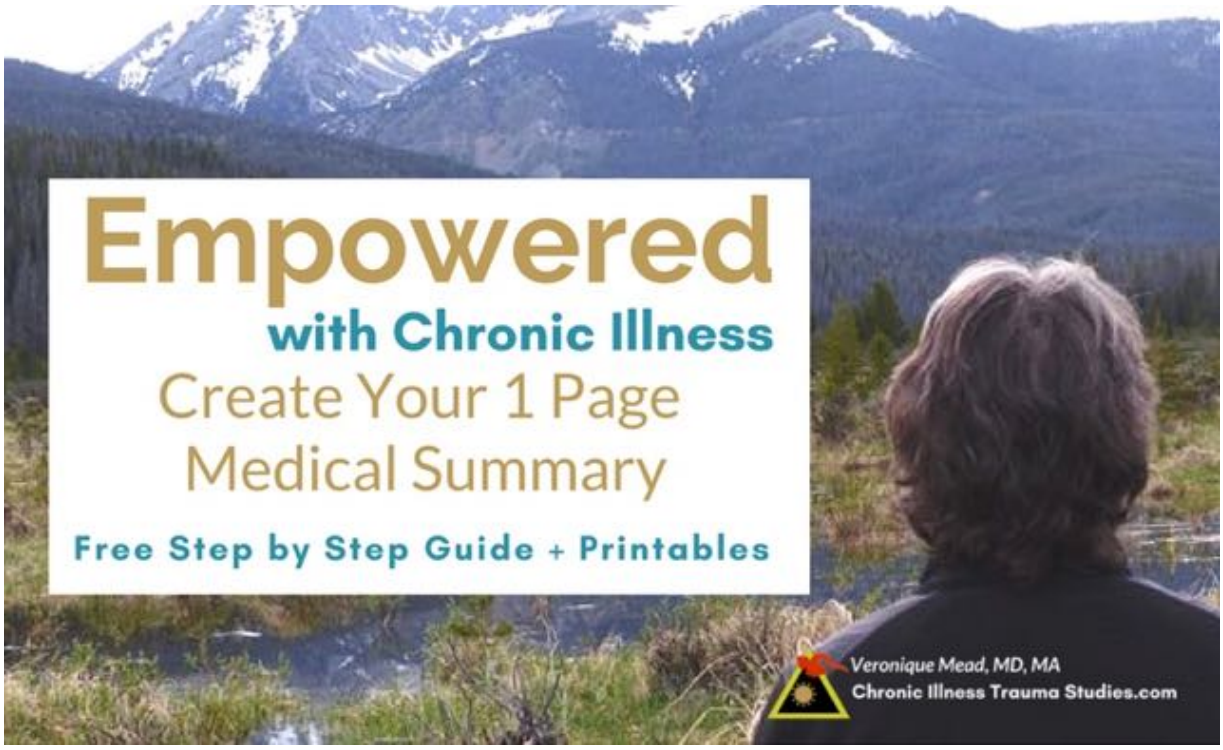


Table of Contents (You Can Click on the Pages)

Introduction	3
Make it Easier for Your Doctor (and Therefore for You)	4
The One Page Summary	4
Step 1: Gather Information & Prepare	6
Step 2: Use These Categories In This Order	7
Step 3: Don't Worry About Length At First	9
The Next 9 Steps For Creating Your Medical Summary	11
1. Chief Concern (CC)	11
2. History of Present Illness	13
3. Medical History & Hospitalizations	14
4. Surgeries & Procedures	17
5. Reproductive History (optional)	19
6. Medications	22
7. Allergies	24
8. Social History	25
9. Family History	31
Tips For Fitting it Onto One Page	33
Step 13: Shorten Your Sentences and Information	33
Step 14: Extra Ways to Make Room On Your Form	35
Step 15. Make it Easier for Your Doctor to Read	38
Step 16: How to Use Your One Page Medical Summary	39
Step 17. Where to Keep Copies of Your Medical Summary	40
Appendix 1 - Example Medical Summary: John Doe	42
Appendix 2 - Example Medical Summary: Jane Doe	43
Appendix 3 - One Page Summary for Emergencies	44
Appendix 4 - If You Have Too Much for One Page	45
Appendix 5 - List of Abbreviations	47

Introduction

Even though I was once a family doctor, it wasn't until I developed a chronic illness and started having to make frequent office visits as a patient that I realized I needed an easy-to-read summary of my history to bring to new doctors and medical appointments.

This was partly because I didn't remember every detail about all of my symptoms, past diagnoses or tests, or medications. It was also because my mind wasn't always sharp when I wasn't feeling well. I was also motivated by the fact that office visits with new health care professionals could be quite stressful since I didn't know how I'd be received. Even though I'm a doctor that doesn't always mean much, especially if you have symptoms that are difficult to diagnose or for which no diagnostic tests exist (I have chronic fatigue syndrome aka myalgic encephalomyelitis or ME/CFS). And finally, it was because I got tired of hand-writing the same summaries and notes every time I scheduled a new medical appointment.

Knowing from personal experience that doctors can get overwhelmed when a patient gives them too much information (even during hour-long appointments), I decided to summarize the important stuff onto single pages. It enabled me to take control of my information, reduce the amount of papers I gave to my doctors, and simplify one small aspect of my chronic illness life. It also supported me to feel more put-together during appointments, which helped me stay more emotionally neutral, regulated and able to see my doctor as a consultant who was there to help me rather than an all-knowing, all-powerful God. In short, it was empowering.

This step-by-step guide will help you create your own one-page medical summary to bring to new doctor appointments, whether you have a chronic illness, have had cancer or a complicated history of other medical problems, need a summary for disability or health insurance applications, or are healthy as a horse but wanting to streamline your or your family's medical records in case of emergencies.

You'll find specifics for emergencies at the very bottom of this guide (or you can link to it directly from the table of contents on the preceding page).

Either way, once you have a summary of your medical history, it'll make appointments run more smoothly, especially if your history is complex. It can also help your doctor listen more fully to the details you have to add, as well as see and feel how you are invested in your health and that you are together in this and part of the same team. It might even put a smile of appreciation on your doctor's face.

Make it Easier for Your Doctor (and Therefore for You)

The One Page Summary

One common reason for seeing a doctor, especially if you have a chronic illness or other long-term health problem, is to get help in diagnosing and treating symptoms as efficiently as possible, so you can find the best treatments available.

Summarizing your history in an easy-to-read, one-page format is a helpful way to give your doctor a quick overview of the whole picture. It includes your:

- present symptoms
- work-ups and test results you may have done so far
- relevant past
- potential risk factors
- possible contributions from family history

This gives your doctor some context and helps them hone in more intelligently on your main problem. There are two examples of one page medical summaries at the very end of this guide.

If you are pretty healthy, one page is all you will need to summarize everything. Even if you have one or more chronic illnesses or a history of complicated health problems, it's still possible to summarize important parts of your history onto one page. If you do have a long medical history, you may find it helpful to make other one-page summaries such as one for each chronic illness. I introduce this in the appendix at the end of this guide.

The same one page summary can be helpful if you're going in for an appointment for a medication refill or for your annual exam.

To start, then, you'll want to create a one page summary of your health history. This is the focus of this guide.

Since most of us see a doctor from time to time, I'll keep things simple by using the term doctor to represent all health care professionals throughout the rest of this post.

Step 1: Gather Information & Prepare

Start with what you know rather than pulling together all your medical records. It's generally what we already do as we fill out forms at new doctor appointments and when our doctors gather our medical histories by asking us questions. What you remember is likely more than enough to create a well-rounded one page summary of your medical history.

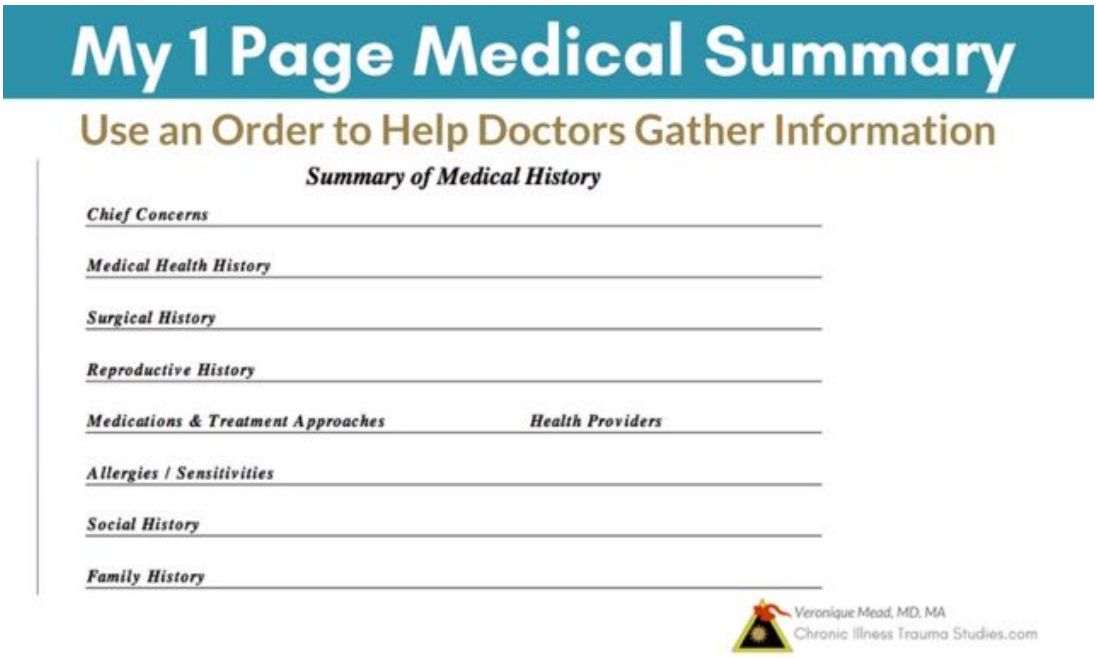
Next, give yourself the time you need so this can feel supportive and empowering rather than overwhelming. Going through your medical history can feel like you are rummaging through every bad thing that's ever happened to you, and can therefore be stressful and emotionally difficult. So take your time. Take breaks and pace yourself. If you have a complicated or eventful history, this is something that you might do over a period of weeks or months rather than days.

Because I have a chronic illness with a number of complicated symptoms, it took some time for me to create my own summary. When I first created my own one pager, for example, I spent a bit of time each day for a week thinking things through and figuring out what to put in (and what to leave out) of my one page summary. But that was the largest time investment I ever had to do. I now spend 10-15 minutes updating it before a specific doctor's appointment. Sometimes it takes me a little more time if a lot has changed or it’s a specialist for a new symptom. I personally enjoy organizing my history, putting the data together and knowing it’ll be helpful.

You can get support by getting help from a friend or family member. You might even collaborate and create your one-page medical summaries with them or with others.

Just remember, *there is no perfectly right way to do this* (no history you'll ever give is likely to be exactly the same, and if 10 different doctors were taking notes while you spoke, each one would summarize your history slightly differently). Figuring out what's important, relevant and how to be succinct takes time and that's completely normal.

Step 2: Use These Categories In This Order



When we are trained to be doctors in medical school, we learn a methodical way to gather a patient's history as a way to keep it in order in our minds. It also helps us make sure we cover all the important parts. Creating your form in this order makes it easier for your doctors to tuck important pieces of information into their heads while they work on helping you solve your problem. This is an especially good format for new doctor appointments when your full history is needed, such as for a new patient visit, a first visit with a new specialist, etc. I'll help you see where to stash little extra bits of information into this framework later on in this guide.

Start with the following 9 categories. Include a line for each event, symptom or diagnosis that fits under the appropriate category. This is your first pass through the process. I'll give you a much more detailed set of examples and explanations below in your second pass. Get my free Microsoft Word document that contains an outline for you to start with your one pager. If you don't already have it it is downloadable directly from the blog post or when scheduling a consult for assistance creating your page. Start entering your information directly into this form. It may take multiple pages at this first pass and that's normal. If you're not sure where something goes take a best guess. I'll give you more details later on.

The following categories are what you'll want to include on your one pager:

Chief Concern. Also called the "chief complaint" or "presenting problem" by doctors: what symptoms or issues are you most needing help with?

History of Present Illness. More details about your chief concern (symptoms, test results if you have any, when it started, etc). This category is optional since the doctor will ask you for more details.

Medical History. Where you list your diagnoses, medical problems and hospitalizations. Anything surgical goes in the next category.

Surgical History. Summary of operations and procedures you've had. Include the type of anesthesia if you have room (local, general, spinal, epidural etc) and any complications or problems.

Reproductive History. This section is for women to document any difficulties with menstrual cycles, pregnancies and births, postpartum events such as depression, symptoms or date of onset of menopause, pain and anything else related to the reproductive system. It's not usually part of a doctor's history in this order but is so common in many women that I've included it here. If you have no concerns in this area, you can leave this category out.

Medications and Other Treatments. Prescribed and over the counter (OTC) meds (herbs, vitamins, supplements, etc). This area is usually specific for medications only but I also use it to present other things you may be doing for your health that are useful for your doctor to know (and that can also convey personal motivation, involvement and investment in your health). Dietary changes, physical therapy, acupuncture, mind body approaches such as meditation can all go here.

Allergies. A list of life-threatening allergies to medications. Include the symptoms you've had that made you realize you have an allergy such as a rash, chest tightness, trouble breathing etc. If you have room you can include any severe food, insect, latex or other life-threatening allergies.

Social History. Your occupation and education, and relationship status (married, single, widowed, etc). What you've done or had for prevention, such as vaccines, screening tests such as mammograms, pap smears, prostate exams. Any life-style risk factors such as smoking, alcohol, etc... This is the place to mention emotional or physical trauma if it has played a role in your symptoms.

Family History. Health problems or chronic illnesses in siblings, parents, grandparents & other close relatives.

Step 3: Don't Worry About Length At First

If you haven't already, go through each category listed above and put down the basic information that feels relevant for each. Start with this step just to see where to put different things from your history.

Try to summarize your history into one line for each topic. For example, if you have a chronic illness, use the first line to list when your symptoms started, when you were diagnosed, and how your diagnosis was made (was it made from antibodies? other tests? history and exam?). On a second line, list test results. Or give one line per test if you need more room. List treatments on a third line. And so on. I have examples in the more detailed format and "next pass" below.

There's no need to include every detail, lab result or test since this is just for a summary. The goal is to get your main information down onto the page in this particular order and in a short format rather than paragraph form. Don't worry about having too much on the page for now. Begin with a broad list of what has happened and see how much you have when you're done.

Once you've put your information into the relevant categories, it'll give you an idea of how much data you have and how much you need to "prune" in order to get it down to a one page summary.

It will also hint at potential other one-page summaries you might find useful to create at some point. For example, if your medical history or list of medications is very long, it could suggest the need for a separate page for your history, for your medications or for both. That'll help you think of what to keep and what to remove in your summary, which doesn't have to include everything. It'll just have the most important information that is relevant today.

Once you've completed this first pass, save it is as your full history with all the information you've taken the time to put in, so you can refer to it again if you need to. Make a copy. Use the copy to now begin to pare it down to your one page summary. This way you don't have to worry about deleting important information or forgetting anything. This could be a stage in your process that you send to me if we are working together in a consult to help you with the process.

Next, look at your information from your doctor's perspective as best you can. As a person with a chronic illness you are likely an expert or becoming an expert and have some more of an idea of what your doctor might want than you ever imagined you'd know. This will help you pare things down to what is most relevant for a particular appointment.

- What issues of yours are still active, and in need of help, treatment or figuring out?
- What issues might your doctor want to know about (diabetes management is ongoing, for example)?
- What can be left out while still conveying the big picture? ie: summarize multiple surgeries
- What issues are completely resolved and therefore potentially removable?
- What can wait until your doctor has a general sense of your main issues?

The following steps will take you through each category for another pass. This will provide examples and will help you shorten things down.

The Next 9 Steps For Creating Your Medical Summary

This second pass is aimed at helping you shorten things. Take your time with each step. I have examples for each category to give you an idea of how this might look.

1. Chief Concern (CC)

The chief complaint is the medical term for the main issue that brings you to your doctor appointments, whether for a new visit or a returning visit. Since this term can sound somewhat judgmental, I like to instead refer to it as my "chief concern" or “presenting concern.”

Your chief concern could be that you need a routine history and physical exam for a new job, in which case that's all you need to state in this section ie: "history and physical for employment." Most often, however, the chief concern is about a health problem you need help with.

On this one page history you want to provide a basic introduction to your main problem. You may have one symptom or there may be 2 or 3 symptoms. Keep each issue to one line. This will be a key way to make it easy for your doctor to read and to fit your whole medical history onto one page.

You don't have to fit everything in this first category (or on this summary page for that matter), since your doctor will ask questions to find out more about your concern when the time is right during your appointment. So don't worry.

You can bring notes with you to your new doctor appointments with any additional details if you'd like reminders for yourself.

If you have a chronic illness, the "chief concern" can be pretty detailed, such as if you have fatigue (like I did) for which you need help figuring out a diagnosis or treatment plan. Maybe you're seeing a new doctor and have had some work-up and tests with other health professionals but don't yet have a clear diagnosis. Some of this might fit in the first line of the chief concern, and some of it can fit in the next category, which is referred to as the "history of present illness."

Example of Symptoms in Your Chief Concern:

Fatigue Fatigue 6/10; ketogenic diet helps slightly; low dose naltrexone no help
Dryness Dry eyes, skin, sinuses; restless legs: worse with stress, carbs+; x 2 years

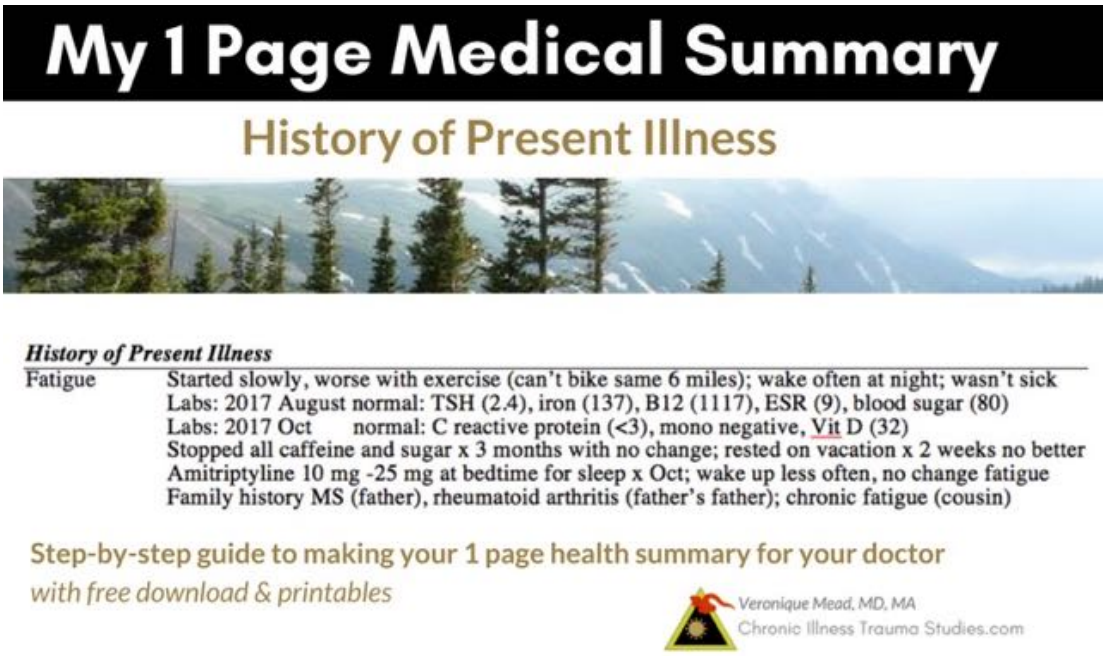
As you gain experience with your form or with an illness if it turns out to be chronic, you'll gradually learn what seems to be the most pertinent information to include. Your summary will keep improving with time. Or you may already know more than your doctor does about your health condition and thus be able to pick and choose what you want to summarize here.

Tip: If you've had a health condition for a long time, you'll probably want to create a separate one-page summary for each specific condition at some point. There, you'll be able to focus exclusively on one illness and can include more history as well as medications you've tried or currently take, old and new test results, treatments you've tried, successes and side effects, and more.

For today, however, we're focusing on your one page summary.

I suggest you list no more than 3 problems, or 3 lines about your chief concern in this first section (as in the example). Your doctor can get more information from you as needed. You may need to set up additional appointments if there is a lot going on with you, since it's often not possible to address multiple different problems in a single appointment.

2. History of Present Illness



If you're in the early phases of trying to get a diagnosis for serious symptoms and are seeing a new doctor or specialist after an initial work-up by your family doctor, this is a place to include basic history about your condition. This could be initial lab and test results, if you've already had some, a little more history about your symptoms and when they began, or how they affect or limit you etc (this is the example in the picture above). If you're having a flare-up of a well-controlled illness and have to see your doctor's colleague for a special on-call appointment (someone new who doesn't know you even if they have their records), or you are seeing a new doctor in urgent care, this is the place to include some background about your chronic condition.

You might leave this section blank:

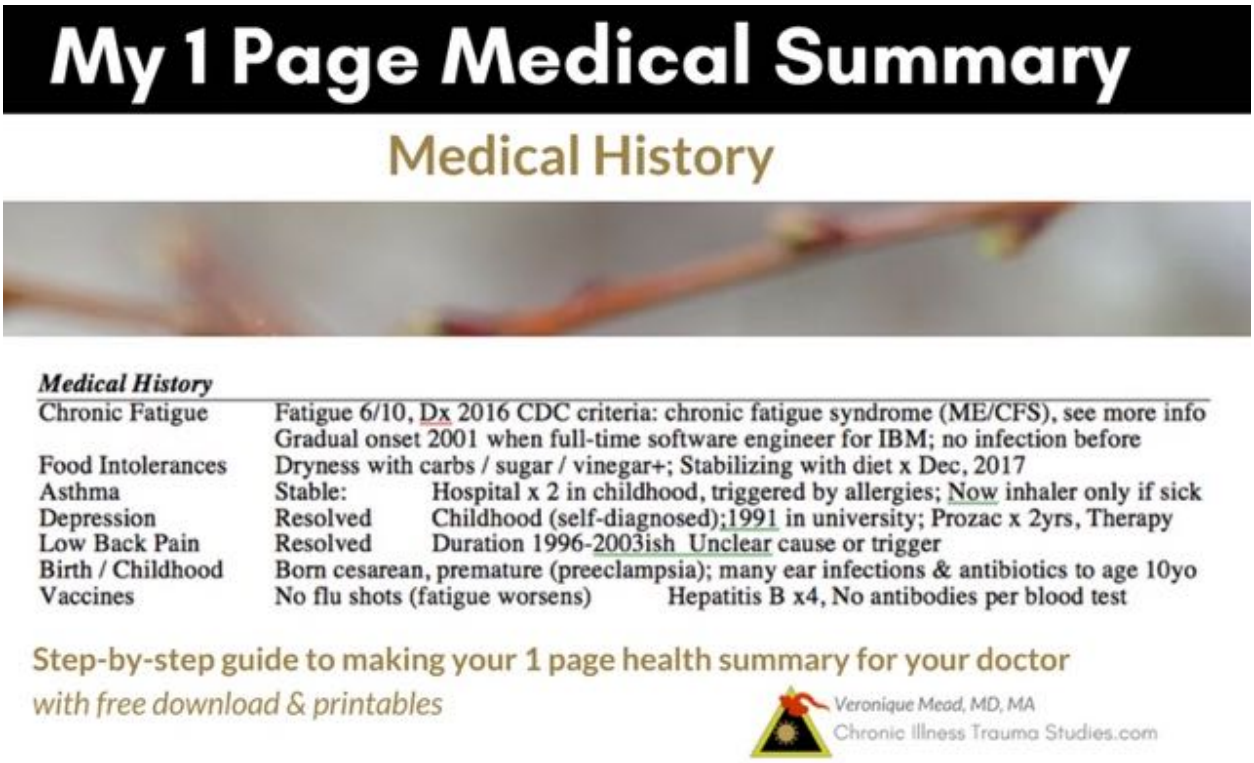
This section on the history of the present illness is is optional. It is only about the issue for today's appointment. If you have a potentially short or straightforward problem such as bronchitis, you may not have anything to add about its history because it's new. If you need a refill or are seeing your doctor for a routine physical and have no concerns, there may be nothing to add here. You can leave this section out sometimes and simply answer your doctor's questions.

If you've had one or more complicated health conditions for a long time and are seeing a new specialist about one of these issues, it can be easier to name your main symptom in your chief concern and summarize your diagnosis under the category called "Medical History" below.

Example in History of Present Illness:

Rheumatoid Disease pain 6/10 most days; onset 2001, antibody positive (RF, CCP), see meds

3. Medical History & Hospitalizations



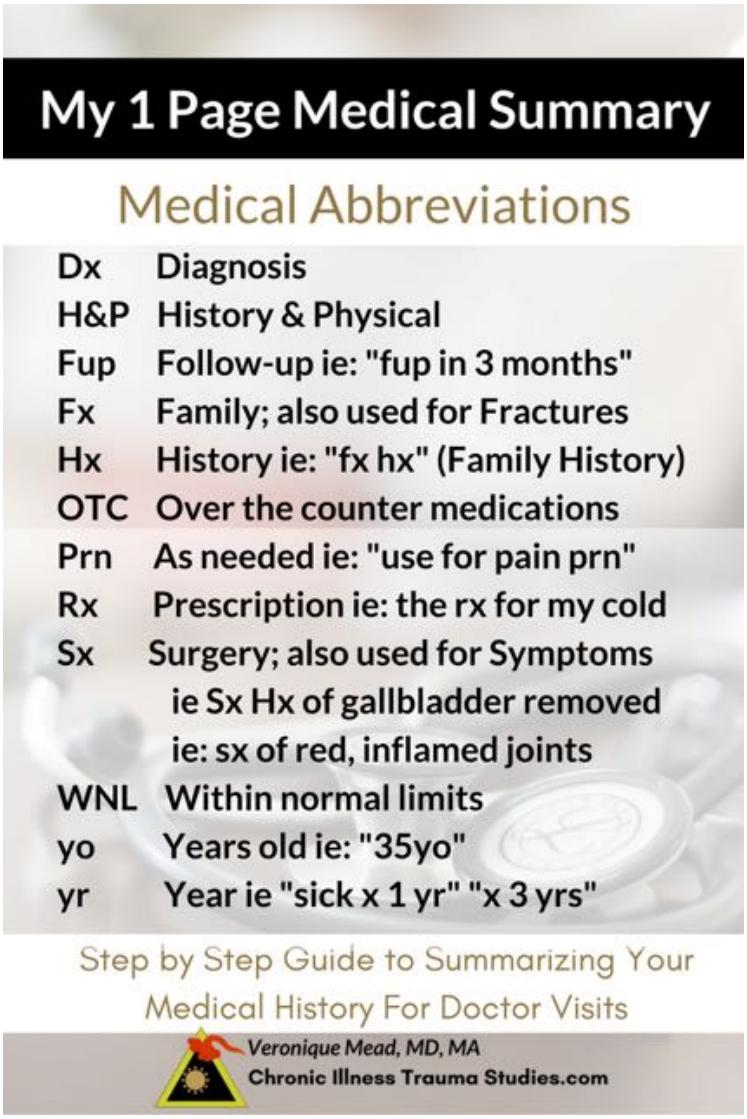
This is a summary of anything medical that has happened during your lifetime (as opposed to "surgical" which is in the next section). It often has the most information for someone with a chronic illness. This area includes serious illnesses or infections, hospitalizations, chronic illnesses and other important diagnoses if you have any, including chronic pain or a particular symptom, even if they are resolved. Try to keep it to no more than one line for any given item.

If you have a complicated illness for which you've had many interventions, hospitalizations or complications over the years, summarize some of these events in more than one line (or a few more if you have the room). Or create a more detailed summary of that particular illness on a separate page. You could say “see page 2 for more info” in this category.

Include your age or the year an event happened. You can shorten a phrase like hospitalized "at 26 years old" to "26 yo" if you feel comfortable with that. I like using the "x" as short hand when describing the number of "times" something has happened.

Example:

Lupus hospitalized x 4 in 20s and 30s, ICU x 2 weeks at 26yo for clot, see page 2 for more info



If you have or have had significant mental health symptoms or diagnoses you can list them in one line here, or as a separate category called Mental Health History after Medical History. If you've had a small number of symptoms or they aren't the main focus of this particular medical appointment or your doctor's specialty, just list them here in a line or two under Medical History. I've included depression under this heading to keep things streamlined in my own history.

Tip: Present your issues in order of priority, starting with the most important, ongoing issues. Put the ones that are still problematic at the top and the least important problems, which may be resolved or stable or in good control, towards the bottom. State if they are resolved or stable so your doctor knows this is not an active problem that needs to be addressed.

Option: One item to include here that most doctor's don't generally think of is your birth and childhood history of any medical problems.

For example, complications during pregnancy and birth can be risk factors for chronic illness. These include being born premature, by cesarean, or because of an illness in your mother (such as preeclampsia/toxemia or gestational diabetes), or because you were sick in the womb (losing weight, you were a twin who was in distress, etc). This is not well known by most medical doctors but is well established in the research literature. It is therefore optional to include.

As another example, having had many strep throats or ear infections in childhood requiring frequent antibiotics can be a sign that your immune system was stressed even when you were a child. Having been treated with a lot of antibiotics is also a risk factor for a decrease in microflora in your gut and other problems later in life for some people (this is shown in the picture above).

Tip Specialists focusing on prevention or on the whole picture are the ones most likely to be familiar with this type of history (functional medicine, integrative medicine, lifestyle medicine, naturopaths etc). You may therefore include this for some of your doctors and not for others.

Example (fits on one line on free <u>downloadable</u> form):

Birth / Childhood Born cesarean, premature (preeclampsia); many childhood ear infections & antibiotics to age 10yo

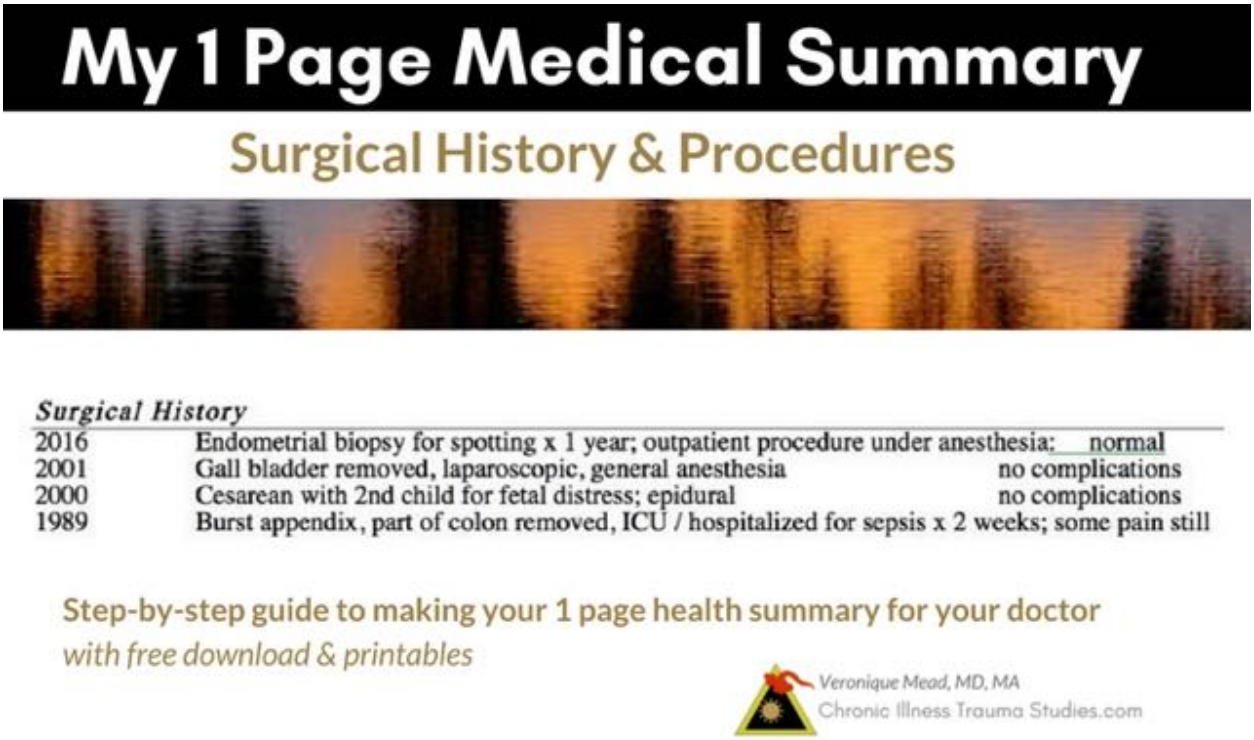
You can decide whether to include this kind of information based on your doctor's specialty, such as if describe above. An immunologist might also find such information useful.

Tip *Of note - this is your form, your history, and your appointment. This is also your relationship with your doctor. While it's often helpful to include everything we're aware of in our history because we can't always know what might be important to them in making sense of our symptoms, you don't have to share everything.*

This is especially true if you feel uncomfortable with the new doctor or because it feels irrelevant for this health care professional's specialty (you may not want to include "depression" in a visit with an orthopedic surgeon, for example).

Trust your instincts and remember that you can always provide more information during new medical appointments, during the work-up for a difficult problem, or in a future office visit once you get to know your doctor better.

4. Surgeries & Procedures



List surgeries and invasive procedures (such as a heart catheterization, joint injection or biopsy, for example) by date. This will help your doctor have a sense of the order of events. You can start with most recent first or last, whichever you prefer.

As in the previous sections, limit each surgery or procedure to one-line or two if needed. You can always highlight or put *** if this was a particularly problematic or important event, if you had complications, or if it's still an issue, in which case it may be part of your chief concern as well.

If you have an illness for which surgeries have been very common, such as inflammatory bowel disease (IBD), you might summarize the most important events in one line.

For example, maybe you've had 5 surgeries, starting when you were 12 years old:

Example:

Surgeries for IBD, x5, first at age 12 yo, most recent at 37yo (2017), colon partially removed

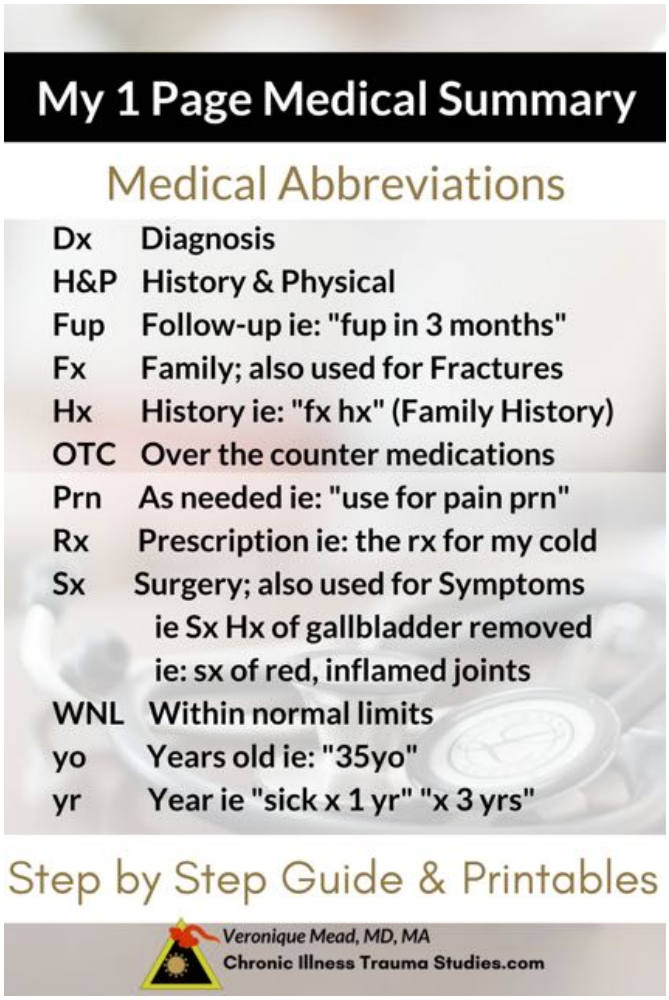
Name the kind of surgeries or procedure you've had and for which diagnosis the procedure or surgery was performed.

Include complications during the surgery or since (such as adhesions, for example, which might also be listed in the section above as a separate or ongoing medical problem). Include any problems you've had with anesthesia, which can go in the Medications category or here.

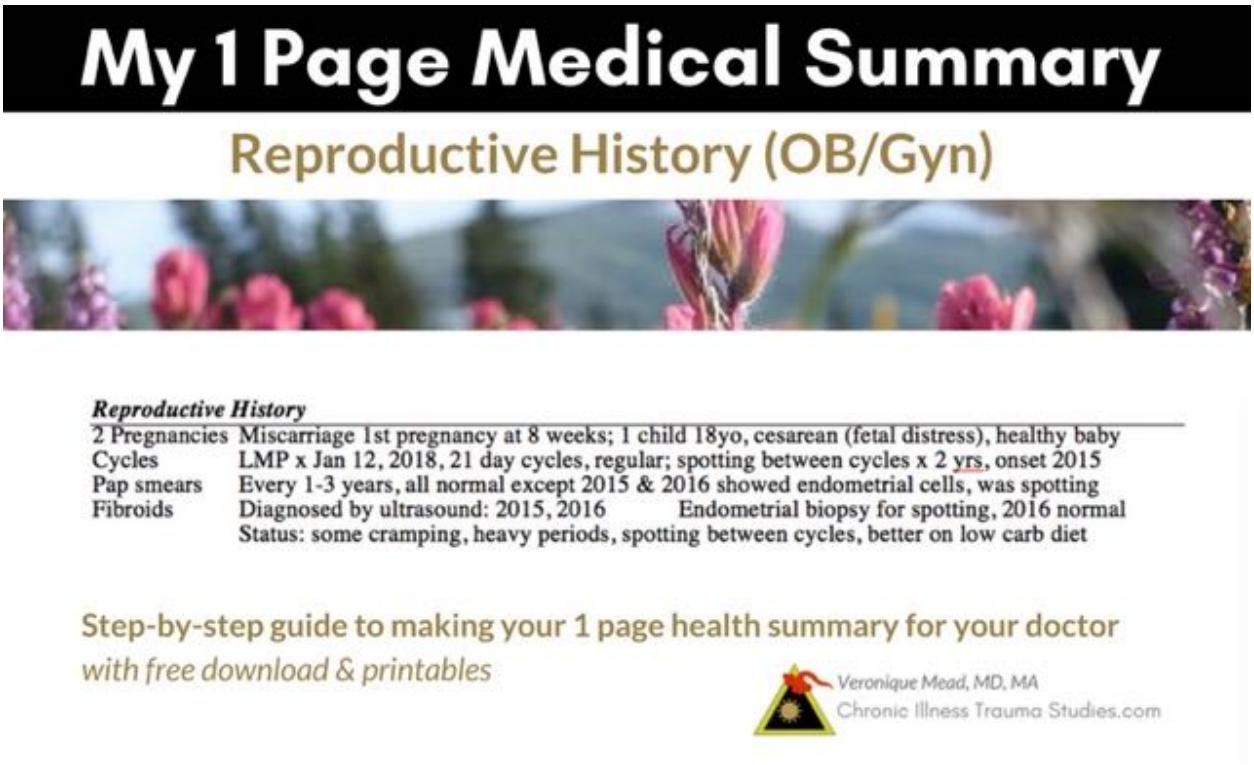
If there's room in your one line, list the kind of anesthesia you had, such as if it was local or if you were put to sleep under a general anesthetic, for example. You will likely have to be selective about what you include in your one liners.

If you are familiar and comfortable with abbreviations that your doctor will understand, feel free to use them.

Tip *Abbreviations can shorten your medical summary and make it much easier to fit more information on one line. Use them only if you really understand and feel comfortable with the terms. This way you won't be confused if your doctor wonders what you meant by a certain abbreviation and you don't remember what it means while in the middle of an appointment when your mind is on other things or because you're feeling stressed.*



5. Reproductive History (optional)



This category contains information that is often asked later in your doctor's gathering of your medical history and sometimes only if you are wanting to get pregnant or have a problem in this area. I've added it here because it provides basic and often important information that is helpful for doctors to know as they try to figure things out (they usually collect this information later in your history).

This category is primarily for women to provide details of pregnancies and births, menstrual cycles, pap smear screenings, and any major problems. I've also included it because symptoms here can be a sign of problems with endocrine or hormonal function.

If you are a man with a current problem in reproductive health, you can list it as a chief concern. If you had problems in areas of your reproductive system such as prostate cancer or infections, you can list it in your medical history, and / or in surgical history and procedures.

If you are nonbinary or transgender or any other category that does not fit female/male this could be a place to list that information, or you could put it in your Medical History.

Gynecological History

If you've never been pregnant or have no symptoms in this area, your summary could be very short. For example:

Never pregnant, regular pap smears since age 18 (all normal), regular cycles since 14yo

For many, it is a little more complex. As everywhere else, try to fit each issue into one or two lines. The information you provide will vary depending on who you are consulting and what for.

You'd usually want to provide more information for your family doctor, obstetrician or gynecologist and maybe just a one line summary for your rheumatologist or orthopedic surgeon. Or you might exclude this category altogether when seeing such specialists.

Start with the age your menstrual cycles first began, age when your periods stopped if you no longer have them. Include the date of your last menstrual cycle (LMP), whether your periods are regular now, or if you have any problems such as severe pain, heavy bleeding, and the state of any problems (stable, resolved, helped by medication, undiagnosed etc). Your sentence could look something like these. You could use the term period or cycle, based on your preference.

Example 1:

Periods started 13yo, regular 21 day cycles, LMP Jan 5th, pain better on birth control pills

Example 2:

If you've had problems, it might look more like this:

Cycle onset 13yo, irregular & painful, better on birth control pills; LMP Jan 5th;

Abnormal pap 2013 age 23yo, biopsy diagnosis HPV+, cryotherapy, normal paps since then

Pregnancies & Births (Obstetrical History)

Include the total number of times you've ever been pregnant. Next, list the total number of times you've given birth and how many children you have had. Include complications you had such as cesarean, forceps, preeclampsia, gestational diabetes, extra long or difficult labors, etc. You can also describe your child's health such as "baby in newborn intensive care unit (NICU) x 4 weeks." Include miscarriages if you are willing, as it's often helpful for your doctor to know if you've had difficulties carrying a pregnancy to term, for example. Abortions are included here as well. If you had a baby that died, include this here as well.

If you don't feel comfortable sharing some of this information on paper, you can tell your doctor in person when or if they ask about this part of your history. You can also leave this entire category out, especially if it's not an area with any concerns.

6. Medications

List your current medications by name, dose, and when you started. Include what you use them for (such as the diagnosis), and any problems or concerns you have. If you have room, include the doctor who prescribed it.

Example:

Albuterol inhaler for asthma, 1 puff as needed, usually only for exercise in the cold, since 6 yo

As in the other sections, you'll decide how much to share here based on what's most important for your particular doctor and medical specialty as well as how much room you have.

If you have a complex illness such as an autoimmune disease and have been on many different meds over 10 years, you may need to create a page summarizing that illness or your medications. In such a case, it's helpful when discussing plans with your doctor for them to know what you've tried, what has caused problems and what did and didn't work. You can list just the basics for this visit with the relevant medications or create a detailed list on another one page summary of the diagnoses you're working with (such as a one page summary for lupus or one page for rheumatoid disease that includes all medications, test results and procedures etc).

Example:

Multiple Sclerosis have tried 6 medications, one trial drug in research protocol, see summary

Abbreviation Tip: Medications that have been prescribed by a health care professional can be referred to as “Rx."

Example:

MS tried 6 Rxs in 8 years (list names if you have room), none long-term helpful; 1 trial research rx (name of drug) in 2014 x 6 weeks, stopped due to side effects

Tip *Feel free to use the well known abbreviations for your illness if the doctor you see will be familiar with it. Not all doctors outside of a specialty area are familiar with some less well-known chronic illnesses such as my own illness, which is better understood if I refer to it as chronic fatigue syndrome rather than "ME/CFS." If in doubt, spell it out.*

Option: Doctors don't traditionally include other treatments under the medication category but if you have a chronic illness and are doing some of the many things that can be helpful for symptoms that have no known cure, you can include them here. These could include dietary changes, meditation, yoga, Tai chi or other mind body practices, etc.

Including your own efforts into approaches that support your healing are especially handy to mention if you are seeing a doctor specializing in the whole person, such as functional, integrative or lifestyle medicine or primary care.

This is one way to convey how much you are doing to get better.

Some doctors recognize and appreciate that you are taking responsibility for aspects of your health that are within your reach (without meaning that you are at fault for being sick and without relying only on what they have to offer, which some doctors recognize can be very little). It can be empowering to show how invested and motivated you are in getting better, and may also help both you and your doctor feel as though you are working to help you get better as a team.

Immunizations

Include immunizations here if you have room. You'll know more about how much room you have to work with once you've finished the first draft of your summary. Immunizations can also go under the prevention section in your social history later on.

7. Allergies

The most common error we make on this section of the form as patients is to list medications that have given us side effects (stomach cramps, indigestion, headaches, ringing in the ears, dizziness etc) that were not actually true allergies. These are drug intolerances and are considered different.

Allergies refer to symptoms that suggest risk for severe and potentially life-threatening reactions in the future if a medication is used again. It's not always easy to know for sure whether you are allergic or simply experiencing side effects that are not-life threatening. Severe and concerning symptoms of allergies can include rashes such as hives, wheezing or airway tightness, chest pain, a very fast and significant swelling at the site of an injection, and other symptoms.

Here are two wikipedia posts with more information about allergies vs drug intolerances.

List the name of the medications (or over the counter meds) you are allergic to, along with the symptoms. If you have room, include the reason it was originally prescribed.

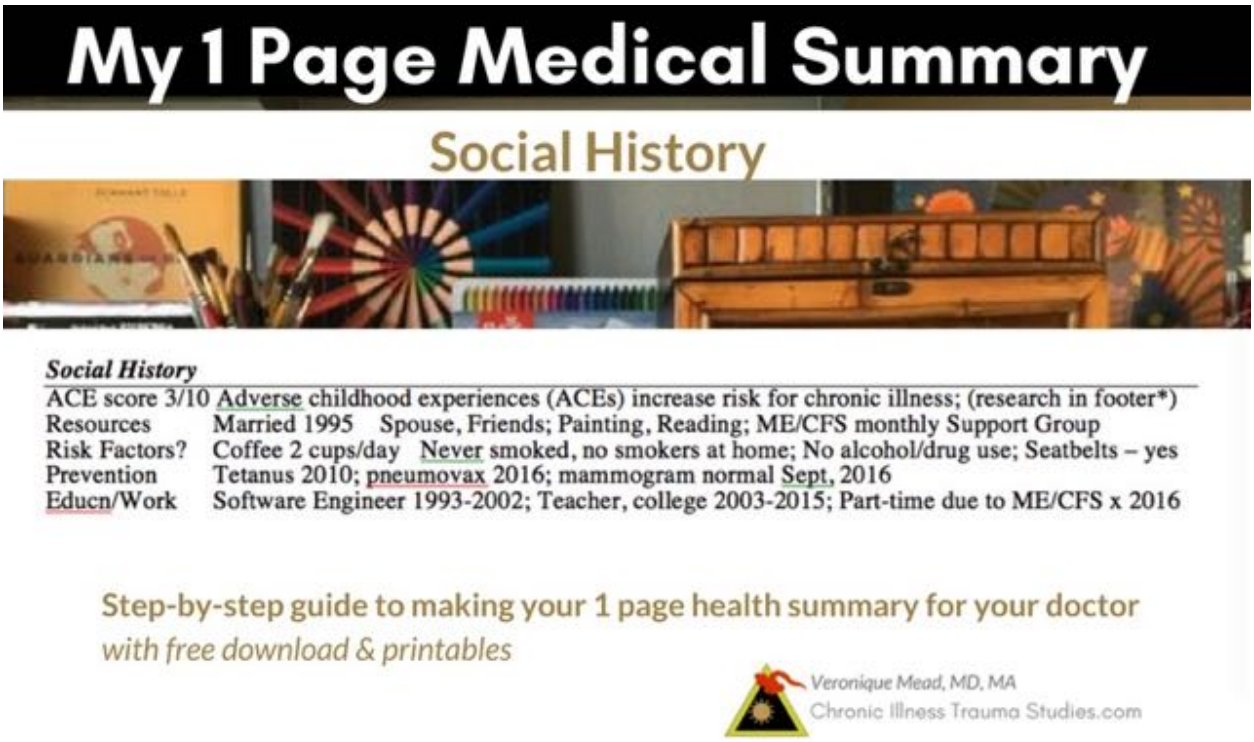
Tip *If you have other severe life-threatening allergies such as to bees or other insects, to certain foods, or to latex (which is used in surgical gloves, for example) and have the room on this page, list them after the medications.*

Examples:

Penicillin hives (urticaria), in childhood, prescribed for ear infection

Food Allergy peanuts, anaphylactic reaction (throat closes); needed epi pen at 4yo, 10yo, 16yo

8. Social History



Your social history is part of a thorough history and physical because it identifies risk factors for health conditions as well as areas that can support wellness, such as exercise and a support system. This is the section most doctors and patients are most tempted to skip.

Wanting to leave out your social history may be especially true if you have many chronic illnesses, or a particularly complicated or long history of illness. And if you really don't have room on your one-page summary, consider it an option to leave this section out, especially if you are seeing a specialist. With a new doctor appointment for primary care such as with a family physician or with someone who will follow you closely and get to know you and hopefully support you over time, however, it's generally helpful to include your social history.

Here are items that you can include in this section.

Work & Education

Occupation and education can be included here. Most importantly for your doctor, your occupation could have something to do with your illness, such as if it exposes you to toxins such as asbestos, intense stress (air traffic controller, police officer) etc. Add this info if you have room and it feels relevant. Add it especially if it feels like a resource for you (maybe you have a degree in a health related field such as nutrition or physical therapy, for example). It's also a potential place to connect on a different level with your doctor, however briefly.

Preventive Care & Risk Factors

Family doctors and other primary care physicians usually have a focus on prevention and supporting health, recovery and wellness. So they may ask about risk factors such as smoking, alcohol use and other substances or recreational drugs, about diet and exercise as well as regular preventive screenings such as mammograms, pap smears, prostate exams (if they believe in them), immunizations such as flu & covid shots and tetanus vaccines, seatbelt use, guns in the home, etc. You can list any or all of these very briefly with a yes or no. You may have mentioned diet under the category "Medications and Other Treatment" and if so, there's no need to repeat it.

Example:

Use seatbelts, exercise 3x a week (walk, swim); no tobacco, alcohol; Mammogram normal at 51yo (2016); colonoscopy normal 2015; last tetanus 2001; Prostate PSA levels normal 2017 Dec

Diet autoimmune paleo, no dairy, sugar, processed foods, grains, nuts; helps my symptoms

Resources In Your Life

Your social history is one of the few places on your form that can be resourcing (and empowering) to include because it's where you can mention some of the support you have in your life (or if you need more).

Doctors don't generally include resources in a social history but you don't have to stick to that. If you have a chronic or debilitating illness, it's especially important to have a support network in your life and to get help in creating some if you don't. It could be an issue you bring to new medical appointments in case they can connect you with someone who can help.

Support can come from a person such as a spouse, family or friends; from a chronic illness community such as support groups; through personal work and process you do such as journaling or therapy. It includes important things you do for yourself, such as hobbies (drawing or photography, growing orchids etc), spending time in nature, or slowing down, etc. You could also list approaches more directly related to treatment and healing, such as mind body practices, in the "Medications and Other Treatment category."

Example:

Resources spouse & friends; quiet time in nature once a week; I have groceries delivered;

Trauma History & Your ACE Score

Most doctors are familiar with trauma being a risk factor for mental health conditions such as PTSD. Most, however, have not been taught about the research showing that adversity affects biology and physiology, increases inflammation and affects our nervous systems, endocrine systems and hormones, and many other biological and cellular functions.

Trauma is a risk factor for autoimmune and other chronic illnesses, as well as a shortened life span. The science and understanding are relatively new to medical doctors and not yet a part of their training even as it is increasingly well established in the research literature.

If you have a history of trauma that has affected your risk for health problems, this is the place to include it if you want to. There are three examples of how to do so: Include your ACE score, give your doctor an ACE Fact Sheet, or list important traumas from your life.

1. List Your ACE Score

Trauma in childhood is currently the most widely recognized type of trauma known to affect risk for chronic illness and other health conditions.

The easiest way to reference trauma from childhood is to list your ACE score if you have one.

The ACE score comes from the adverse childhood experiences (ACE) studies. They show that difficult events in childhood greatly increase risk for all types of chronic physical and mental health conditions, including autoimmune diseases.

Your ACE score is based on whether you experienced any of 10 specific types of trauma before your 18th birthday:

1. physical abuse
2. emotional abuse
3. sexual abuse
4. physical neglect (not enough food, shelter, clean clothes etc)
5. emotional neglect
6. losing a parent through divorce or separation (death is not officially included but counts)
7. having a household member in jail
8. having a household member who abused substances such as alcohol
9. having a parent with a mental illness
10. witnessing violence between your parents.

You add one point for each type of adverse event you experienced for a total of up to 10. Only one point per event if it happened more than once etc This is your ACE score.

The ACE questionnaire only covers a fraction of the types of serious life events and traumatic events that are known to affect health. The ACE studies are the most well-known and sometimes used as a screening tool in medical practices.

If you use your ACE score on your medical summary, it's all you need to do. You don't need to list which types of trauma you experienced because the study findings simply show that the higher your score, the greater the risk for chronic health conditions and other problems.

As an example, the risk for hospitalization from an autoimmune disease goes up to 70% with an ACE score of 2 compared to an ACE score of 0.

Tip If you are really into documenting the role of trauma and educating your doctor, you might include a reference article in your footer of your medical summary. The very first ACE study was done in 1998 and is a great article for physicians and other health care professionals that shows risk for many different chronic diseases. This is one way of educating your health care professional if you want to.

Example:

*ACE score 6 Studies of adverse childhood experiences (ACEs) show increased risk for chronic illness (*see study in footer)*

You could include this ACE study in the footer of your one page medical summary. The First ACE Study:

Felitti, V. J., et al. (1998). "Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study." American Journal of Preventive Medicine 14(4): 245-258.

Learn more about the ACE studies, see the questionnaire and calculate your score in this blog post.

2. Give Your Doctor an ACE Fact Sheet

Another option to include your trauma history or educate your doctor is to download one of the ACE fact sheets on my blog to give your doctor. These two fact sheets each summarize the science, facts and statistics on one page. They include one page with references to support the strength and validity of this well studied topic, and a third page with the ACE questionnaire.

These are the two fact sheets to choose from:

•Chronic illness ACE Fact Sheet lists over 20 diseases known to be increased with a history of ACEs. There is no mention of risk for mental health conditions in this fact sheet, which some doctors think as being the only effect of trauma.

•All Effects of ACEs lists chronic illness, cancer, as well as mental health conditions, addictions, shortened life span and many of the other known effects of ACEs.

My own ACE score is about 2 and my trauma history is so subtle I thought it was zero for years. So I don't include it in my medical summary (you can learn more about my story and how trauma has helped me make sense of my ME/CFS). I'm open to talking about it if a health care provider is interested, but don't otherwise like to bring it up given that few doctors are trauma aware and that there may be judgement about the role of trauma. On the other hand, journalist Christine "Cissy" White used her high ACE score with select health care providers to convey the validity of her symptoms without having to delve into the details of her past. Here's a great example of how she used her ACE score for a medical appointment when seeing a new provider for a prescription refill.

3. Include Important Traumas in Your Social History

If you have an ACE score and other trauma, you can include both in your social history. Or you can just include types of trauma you've experienced or if you have an ACE score of zero like I do.

Types of trauma that have affected your onset of symptoms, flares or that act as triggers might include an accident, the loss of a loved one, having been a caregiver for a loved one, a history of abuse, or intense stress at work, among others. It could also be that you have served in the military or lived in an unsafe neighborhood as a child, and more.

Tips on Whether to List Trauma or Not

Knowing about trauma can help informed doctors make sense of your health conditions and refer you to helpful resources as well as skilled practitioners for support and treatment.

Since most doctors still have little training in understanding trauma in chronic physical health conditions and often still believe its effects are only psychological, this may or may not be an item you want to include in your history.

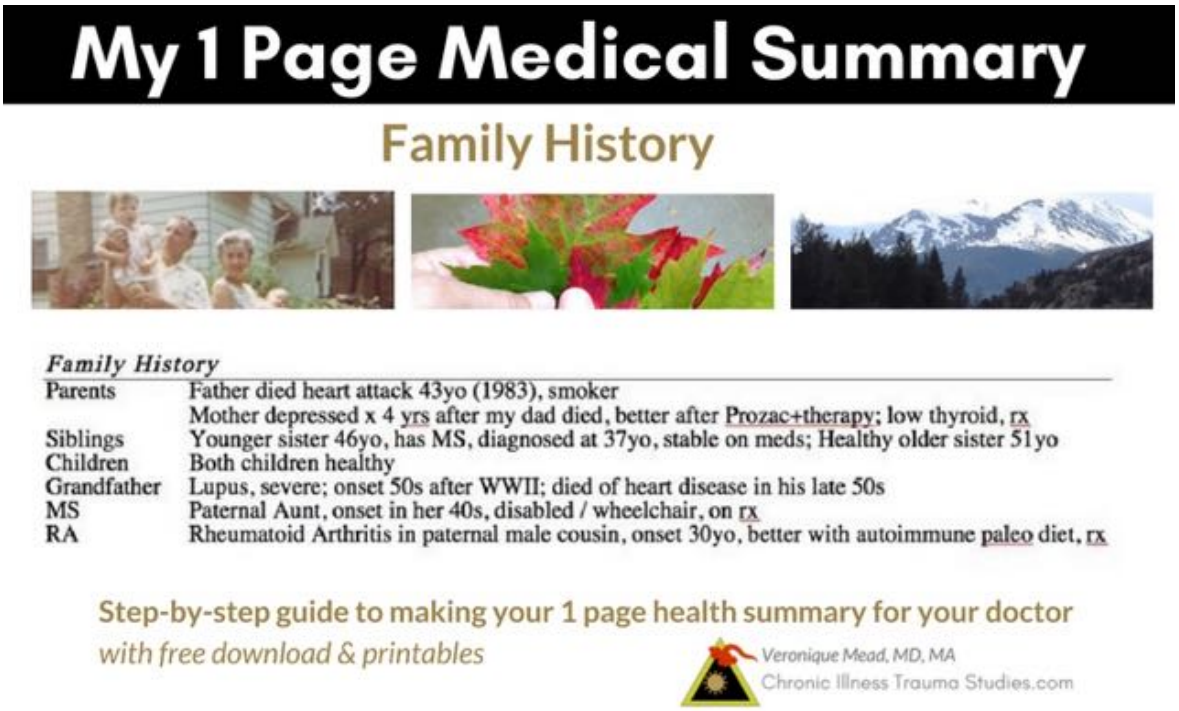
It also depends on the doctor you are seeing and their specialty. Doctors specializing in the whole person are more likely to have some familiarity with the research.

Such specialties include:

- functional medicine

- integrative medicine
- lifestyle medicine
- some primary care doctors (internal medicine, family doctors, pediatricians)
- naturopaths and other practitioners in fields of alternative health care

9. Family History



List significant illnesses in your closest relatives here. This includes brothers and sisters, parents, and grandparents. If you have a more distant relative with a related or seemingly relevant illness to your own, list them here too. For example, I have multiple cousins and aunts who have been diagnosed with chronic fatigue syndrome, just as I have been. If you have room, include whether the person is on your mother or father's side of the family.

Tip *You can create the list starting with who your relative is (mother, father, grandparent) or start with the name of the illness. If you feel comfortable, you can use the abbreviations for diagnosis (Dx) and prescription (Rx) here. Has a diagnosis of type 2 diabetes, on multiple medications could be shortened to, "dx type 2 diabetes, on multiple rx"*

Include their age in years (72 years old can be shorted to 72yo).

As mentioned earlier, I also like to use an "x" to shorten how often or how long something has occurred. For example, "has had type 2 diabetes for 20 years" can be listed as "type 2 diabetes x 20 years."

Example 1 Sentence with Each Relative:

Parents *Mother (72yo) in good health*

Father *Died heart attack age 56yo, was smoker, had diabetes type 2 x 20 years*

Brother *MS, diagnosed at 54yo, stable on meds*

Sister *Depression, PTSD after military service, on rx, better after trauma therapy*

Grandpar *Rheumatoid arthritis in paternal grandfather, died in 80s of heart condition*

Example 2 Sentence with Diagnoses / Illnesses:

RA *paternal grandfather; severe, major joint deformity; died in 80s of heart condition*

Thyroid *mother dx low in her 50s, stable on small dose rx; maternal aunt low thyroid on rx*

ME/CFS *3 maternal cousins, 1 dx with epstein barr; 2 aunts with ME/CFS, father's side*

Tips For Fitting it Onto One Page

If it all fits onto one page you are good to go.

Because I've had a chronic illness for 20 years, I find that once I've filled in all the categories above it is another step in the process to pare down my detailed medical history to one page. This additional step takes time and that's normal.

Step 13: Shorten Your Sentences and Information

I start this next process by seeing how many lines I have gone beyond the first page and onto a second. If I have 2 whole pages of information, it indicates that I probably need a separate one page summary for the topic that takes up most of the space (medications? labs and test results? a chronic illness or two or more? You can find more information in the appendix on what to do when you have a lot of information).

If I just have 4 to 10 lines extra on the second page, I know I can probably make it fit into one page. And I know that's how much space I need to create.

So I start with whichever category feels easiest to me to shorten. Family history, for example, can be a place to shorten with relative ease. Maybe you can fit both of your parents' health histories onto one line instead of two, and the same with other family members as you decrease some of the detail provided.

This is also where you might be tempted to use abbreviations. If you're comfortable with them, use them. Or you might find other language to use instead of the words you first chose ("mammogram ok" instead of "mammogram normal"). If not, consider leaving details out instead. Your doctors can always get more information from you if they want it.

Shortening your history and trying to get it to fit on one page by adjusting a word here or joining two lines there can feel fussy or finagle-y but it's what creates an easy-to-read summary that is quick for your doctor to scan. Stay with it. And if you need help, ask someone you trust, such as a compassionate family member, friend or colleague. Another option is to schedule a consult with me to help with this process.

Example of a Shortened Family History From Above:

Parents *Father died heart attack (56yo), smoker, diabetes type 2 x20yrs; Mother healthy (72)*

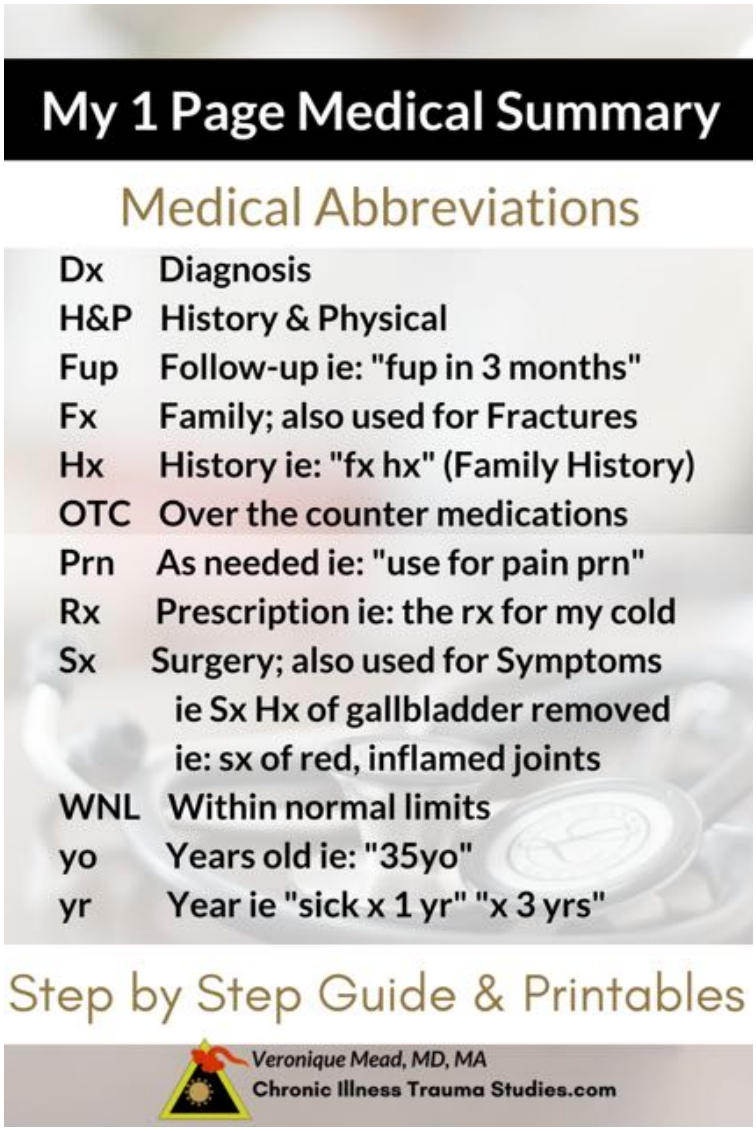
Siblings *Brother, MS, dx 54yo; Sister, depression, PTSD (veteran), on rx*

Social history could be another place to shorten and highlight only what you most want your doctor to know.

ACE score 6/10; Married, 2 kids; No tobacco; Pap & Mammogram ok (2016); Tetanus 2001

Remember that you don't have to include everything that has ever happened to you. Your doctor can ask and you can tell them there's more.

This shortening process might make you want to use abbreviations so here's the image with a list once again.



Step 14: Extra Ways to Make Room On Your Form

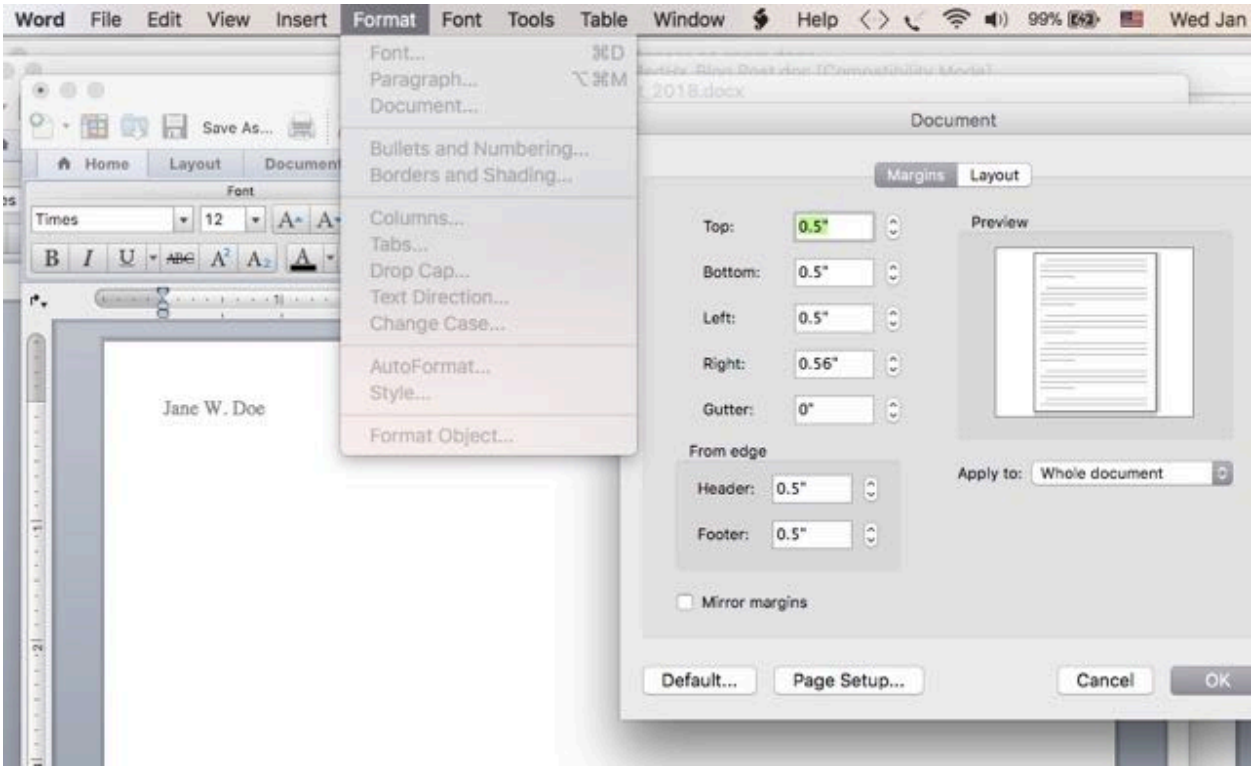
If you have a lot of information that does not fit into a single page, you can increase the amount of space you have to work with. I do the following things.

---

1. Widen the margins (included in the free downloadable form).

If you are making your own form, start by creating a new document (I use Microsoft Word on a mac). From the pull-down menu, select format > document. Make the top, bottom and side margins smaller. I like to set all of mine to 0.5 (and the right one to .56), which gives you the maximum amount of usable space and still allows everything to be visible on a printed page (this is how the document you can download is formatted).

Keep your font to a normal size so it's easy to read and scan. I use Times and a 12 point font.



2. Place your name and basic info in the header at the very top

Jane A. Doe Medical Record # A123456 DOB 1/10/1970 Age: 48 Jan 2018

Summary of Medical History

Chief Concern

Chronic Fatigue	Fatigue 6/10; ketogenic diet x3 months helps slightly; no help low dose naltrexone 3mg
Dryness	Dry eyes, skin, sinuses; restless legs: worse with stress, carbs+; x 2 years

Medical History

Chronic Fatigue	Chronic fatigue syndrome (ME/CFS) Diagnosed 2016 criteria CDC website; see page 2
	Gradual onset 2001 when full-time software engineer for IBM; no infection before
Food Intolerances	Dryness with carbs / sugar / vinegar+; Stabilizing with diet x Dec, 2017
Asthma	Stable: Hospital x 2 in childhood, triggered by allergies; Now inhaler only if sick
Low Back Pain	Resolved Duration 1996-2003ish Unclear cause or trigger
Depression	Resolved Childhood (self-diagnosed);1991 in university; Prozac x 2yrs, Therapy
Vaccines	No flu shots (get sick) Hepatitis B x4, No antibodies per blood test
Birth / Childhood	Born cesarean, premature (preeclampsia); many ear infections & antibiotics to age 10yo

Surgical History & Procedures

2016	Endometrial biopsy for spotting x 1 year; outpatient procedure under anesthesia:	Normal
2001	Gall bladder removed, laparoscopic, general anesthesia	No complications
2000	Cesarean for fetal distress; epidural	No complications
1984	Burst appendix, part of colon removed, ICU / hospitalized for sepsis x 2 weeks; some pain still	

Reproductive History

2 Pregnancies	Miscarriage 1st pregnancy at 8 weeks; 1 son 18yo, born cesarean (fetal distress), healthy baby
Cycles	LMP x Jan 12, 2018, 21 day cycles, regular; spotting between cycles x 2 yrs, onset 2015
Pap smears	Every 1-3 years, all normal except 2015 & 2016 showed endometrial cells (I was spotting)
Fibroids	Diagnosed by ultrasound: 2015, 2016 Endometrial biopsy for spotting, 2016 normal
	Status: some cramping, heavy periods, spotting between cycles, better on low carb diet

Medications & Other Treatments	***Health Providers***
Albuterol inhaler, as needed, rare use (x only need when sick)	For asthma Dr. A, MD Family Doctor
Low Dose Naltrexone 3 mg/day x Dec 2017	For ME/CFS Dr. B, MD Immunologist
Vit D 1000 mg/day; Tylenol and/or ibuprofen for cramping, abdominal pain on occasion (Dr. A)	
Bactrim : Sensitivity? Hx lightheadedness, weakness last time Rx for urinary infection (2011) (Dr. A)	
Other Treatment: Meditation 20min/day; acupuncture	For ME/CFS+ Dr. D, DAc Acupuncture
Diet: Ketogenic –meat/veggies, no sugar/dairy/fruit	For dryness, ME/CFS
	Provider C, MSN Nutritionist

Allergies

Penicillin:	Hives in childhood, Prescribed for ear infection
Latex gloves:	Hives, itching, chest tightness; Started in 2016

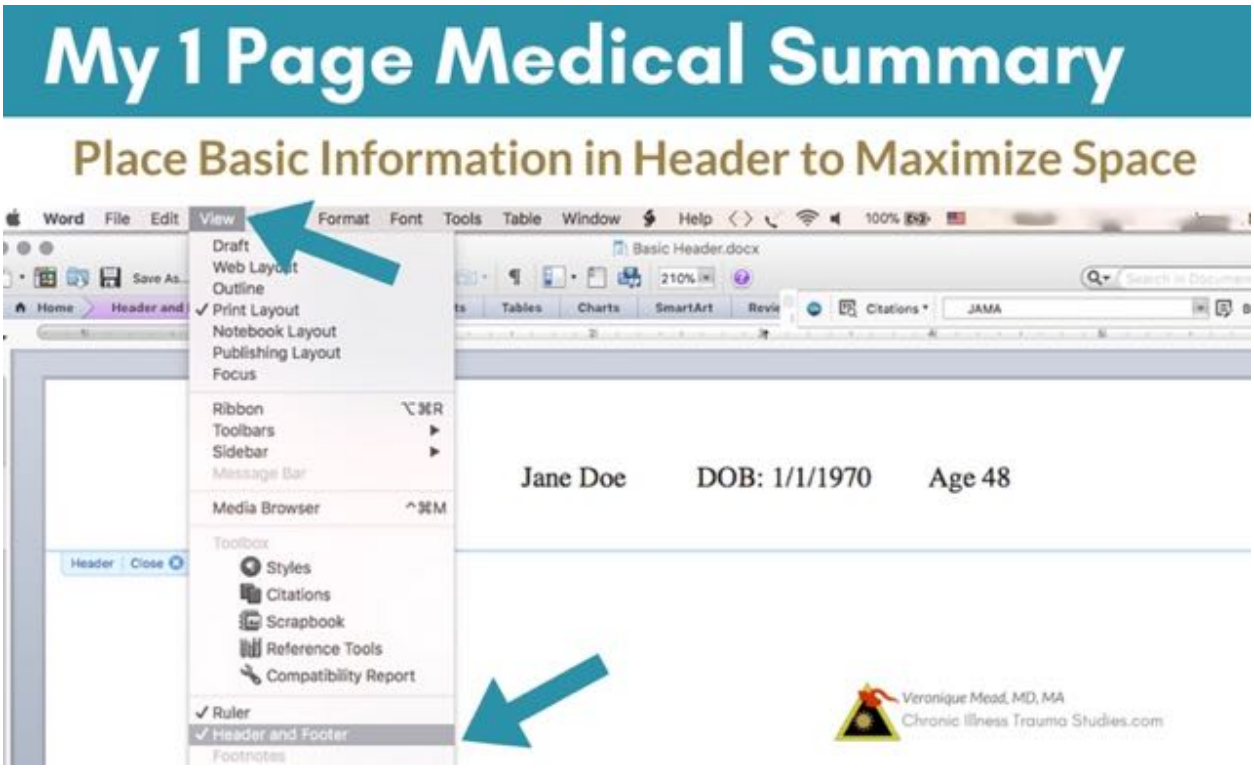
Social History

ACE score 3/10	Adverse childhood experiences (ACEs) increase risk for chronic illness; (see study in footer*)
Resources	Married 1995 Spouse, Friends; Painting, Reading; ME/CFS monthly Support Group
Risk Factors?	Coffee 2 cups/day Never smoked, no smokers at home; No alcohol/drug use; Seatbelts – yes
Prevention	Tetanus 2010; pneumovax 2016; mammogram normal Sept, 2016
Educn/Work	Software Engineer 1993-2002; Teacher, college 2003-2015; Part-time due to ME/CFS x 2016

Family History

Parents	Father died heart attack 43yo (1983); smoker (his father died of same in his early 40s see below)
	Mother depressed x 4 yrs after dad died, better after Prozac + therapy; low thyroid, on rx
Siblings	Younger sister (46yo) has MS, diagnosed at 37yo, stable on meds; Healthy older sister (51yo)
Grandfather	Lupus, severe (my father's Dad) onset in his 30s after WWII; died of heart attack in his 40s

* ACEs: Felitti, V. J., et al. (1998). "Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study [see comments]." American Journal of Preventive Medicine **14**(4): 245-258.



I like to put basic information in the header area in order to maximize space for everything else. You access it by double clicking in the area (or using the drop-down menu > view > "header and footer". Keep your identifying information to one line if possible or to two lines max. If more information is necessary you can always add it to the footer.

Things I include in the header are:

First and Last Name. Include your middle initial if it's useful or your name is common

Date of Birth (dob).

Your Age. This makes it easy for your doctor to know how old you are at a glance instead of having to calculate it.

Other bits of information may be relevant, such as if this one page history is being mailed to your disability insurer or health insurance company and you want to include your medical record number or claim number and contact information such as address, phone number or email.

Step 15. Make it Easier for Your Doctor to Read

1. **Headers (included in the free downloadable form).**

Make your summary easier for your doctor to scan and read by grouping your information.

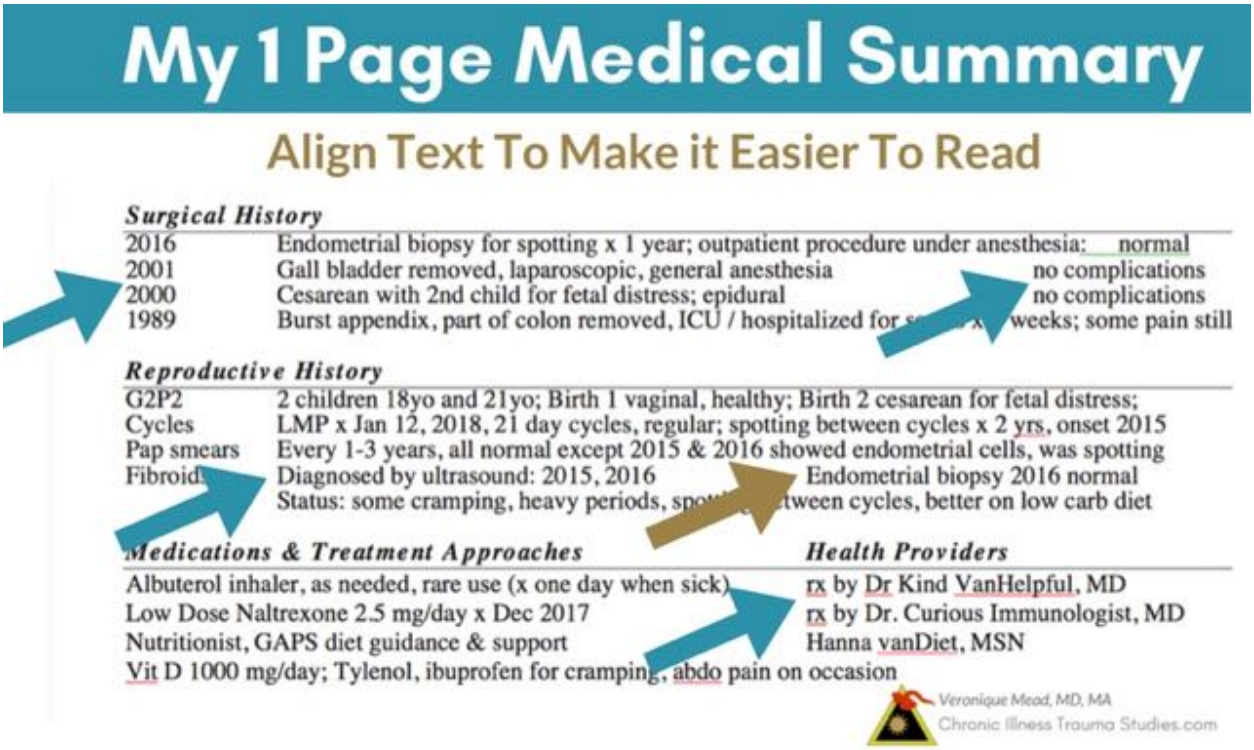
You can use MS Word's formatting tools if you know how to use them or simply make headers stand out by using **bold,** *italics* and underlining. See the example in the picture above where each category is clearly marked.

I make the header bold and italics and create a line underneath. To do so, go to the line below your header, press shift and the dash sign to enter three hyphens and hit return. In MS word this creates a line below your header that fills the entire width of the page. These headers and lines are included in the free formatted form that you can download.

2. **Line up Your Content and Capitalize Phrases.**

This step is certainly not required but if you have the energy and time or someone to help you, lining up and capitalizing the beginning of your phrases will also make the page easier for your doctor to read and scan.

Line information up: The arrows point to areas where information lines up or there is a space.



Step 16: How to Use Your One Page Medical Summary

1. I bring 2 copies of my medical summary to new doctors, one in case the doctor is interested (not all of them will be) and one to help me recall details and jog my own memory.

2. I like to wait until I meet and start talking with my new doctor before handing it over. When they ask why I'm there I tell them briefly and explain I have a one page summary of my complex medical history. I ask if they'd like to see it.

   "I'm here because I've had problems with fatigue for the past 6 months. My family doctor has done an initial work-up. The medications aren't helping and I need a deeper investigation. I've summarized some of the results and my medical history on a page, would you like to see that?"

   Or, you could tell the receptionist when you first check in or the nurse who checks you in that you have a summary of your medical history and ask if they'd like to attach it to your chart for your doctor to review before the appointment. Since most doctors don't have extra time to review much if any of your chart before they step in to see you (there's no such timeline built in to doctors' schedules unless this is something they personally include in their routine), I prefer not to add anything to their chores before they see me.

   I also like to know if my doctor is interested so I like to be there when they scan the document. That way I can answer questions if they have any. I also get to see how they react (interested? curious? overwhelmed?), and adjust my responses accordingly, such as waiting quietly while they read it, making more effort to keep things short and non urgent if they seem overwhelmed, and staying as open as I can to following their lead if this doesn't seem to be the way they like to gather information.

3. Having a copy of my summary in hand helps me remember that I am already whole, that I am okay just as I am (even if I'm sick, it is not WHO I am), and that I am just as "valid" a person as my doctor is. It reminds me that:

   I am there to consult someone for specific skills (western medicine and not an all-knowing “God”).

   They will probably not have all the answers even as they might be able to assist me on my quest for better health.

   Even though I need their help (and I may have significant feelings of desperation or urgency because of how sick I might be), I have choices in who I see and how I act.

   The doctor’s questions can inform me about details that might be useful to include on my form with future new doctors (such as certain lab results, for example).

   I can assess how I feel about this particular doctor. How well do they listen? How do they respond to my own investment of time and will power and participation, such as major

changes in diet or daily meditation? Are they open to my contributions, such as the research on trauma as a risk factor for chronic illness (and not just for mental illness)?

4. Having my medical summary in hand, even if the doctor prefers to gather my history verbally, reminds me who I am and what I want. It is a tool I use to help me stay as empowered as possible during medical appointments.

Step 17. Where to Keep Copies of Your Medical Summary

I store my medical summary in a folder on my computer called "Health" and in a subfolder called "Summary Documents." I update it regularly as new test results come in (which also helps me easily compare with past results), new symptoms emerge or resolve, or if I want to tweak it because I have an appointment with a new doctor for whom I want to update, refine or remove certain parts of my history.

I save each major update for a new doctor as a new document so I always have the polished older one pager as a backup.

Once you've got it all shortened down to one page, your one page medical summary is good to go!

If you want to keep a copy for emergencies, you can fold it and store a copy in your wallet, purse, pocket or glove compartment. Or keep a copy with other important documents such as your will and advanced directives in a safe place.

I wish you all the best in creating your summary and that it feels as supporting and empowering for you as it has for me.

warmly,

Veronique

Appendix 1 - Example Medical Summary: John Doe

Jonathan Doe Medical Record # A123456 DOB 01/10/1960 Age: 58

One Page Example Summary 2: Jonathan Doe

Chief Concern

Chest Pain	x 2 weeks, after climbing first floor to apartment, feel winded, ok after 1 nitroglycerin

History of Present Illness

Heart Attack	September 28th, 2003 (43yo), CCU x 3 days; Had heart catheterization, 1 blocked artery, opened with balloon Stopped smoking after heart attack
Diet	Low fat, no red meat, veggies with lunch and supper
Exercise	Less since my wife died: Walk 3 x/ week x 20 minutes, used to also walk to work

Medical History & Hospitalizations

High Blood Pressure	Average 140/80 to 150/90;	Fatigue with atenolol was a problem.
Diabetes Type 2	x 15 years; dx age 43 (Sept, 2003);	A1C: 8 (Jan 5, 2018) AIC 7.5 Oct 2017
Weight	Having trouble losing weight, eating more desserts, walk 2-3 times a week	
Neuropathy	Numbness in toes on right foot; Pain at night, left foot – no change x 2 years	
Immunizations	Flu shot every fall	

Surgical History & Procedures

Cardiac Cath	Sept 2003 after heart attack; 1 vessel partly blocked, opened with balloon	
Appendix	June 5, 1998, after belly pain x 3 days; general anesthesia	no problems

Medications & Treatment Approaches		***Health Providers***
Name of Medication 1 for Diabetes	date started, dose	Prescribed by Dr A
Medication 1 for Blood Pressure	date started, dose	Prescribed by Dr X
Medication 2 for Blood Pressure	date started, dose	Prescribed by Dr X
Medication 3 to prevent heart attack	date started, dose	Prescribed by Dr X
Atenolol	Tried for blood pressure, fatigue was too severe (I couldn't work)	
Nitroglycerin sublingual tabs 0.3mg	prn since September 2003; using every day x 2 weeks, Rx by Dr. X	
Over the counter: aspirin 1 baby / day; Tylenol for pain as needed; Benadryl as needed (spring allergies)		
Other Treatment	Started acupuncture Jan 10th to help with neuropathy, weight	

Allergies

None

Social History

ACE score 6/10	Adverse childhood experiences (ACEs) increase risk for chronic illness; (see study in footer*)
Married	x 35 years, wife died August 2017 (car accident); 3 kids; Human Resources at IBM x 20 years
Prevention	flu shots every year; tetanus 2012; stopped smoking 15 years ago after heart attack; no alcohol
Resources	started meditating Jan 5th, 20 minutes/day; play cards with friends Thursday nights
Risk Factors	smoked from 20 years old to 43yo; my weight;
Other	1-2 glasses wine with supper at night

Family History

Mother	died at 46 alcoholic; liver disease; bipolar disorder;
Father	diabetes type 2, amputation left leg below knee at 59yo; gets around with wheelchair
Children	2 daughters 38yo has problems with weight; type 2 diabetes; 36 yo high blood pressure; son 34 yo, type 1 diabetes dx 17 years old, married with 2 children in good health
Grandfather	Father's side: High blood pressure, died from complications of diabetes at 67yo
Grandparents	Mother's side: mental illness (don't know what kind), alcoholic; did not know very well

* ACEs: Felitti, V. J., et al. (1998). "Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine **14**(4): 245-258.

Appendix 2 - Example Medical Summary: Jane Doe

Jane A. Doe Medical Record # A123456 DOB 1/10/1970 Age: 48 Jan 2018

Summary of Medical History

Chief Concern

Chronic Fatigue	Fatigue 6/10; ketogenic diet x3 months helps slightly; no help low dose naltrexone 3mg
Dryness	Dry eyes, skin, sinuses; restless legs: worse with stress, carbs+; x 2 years

Medical History

Chronic Fatigue	Chronic fatigue syndrome (ME/CFS) Diagnosed 2016 criteria CDC website; see page 2
	Gradual onset 2001 when full-time software engineer for IBM; no infection before
Food Intolerances	Dryness with carbs / sugar / vinegar+; Stabilizing with diet x Dec, 2017
Asthma	Stable: Hospital x 2 in childhood, triggered by allergies; Now inhaler only if sick
Low Back Pain	Resolved Duration 1996-2003ish Unclear cause or trigger
Depression	Resolved Childhood (self-diagnosed);1991 in university; Prozac x 2yrs, Therapy
Vaccines	No flu shots (get sick) Hepatitis B x4, No antibodies per blood test
Birth / Childhood	Born cesarean, premature (preeclampsia); many ear infections & antibiotics to age 10yo

Surgical History & Procedures

2016	Endometrial biopsy for spotting x 1 year; outpatient procedure under anesthesia:	Normal
2001	Gall bladder removed, laparoscopic, general anesthesia	No complications
2000	Cesarean for fetal distress; epidural	No complications
1984	Burst appendix, part of colon removed, ICU / hospitalized for sepsis x 2 weeks; some pain still	

Reproductive History

2 Pregnancies	Miscarriage 1st pregnancy at 8 weeks; 1 son 18yo, born cesarean (fetal distress), healthy baby
Cycles	LMP x Jan 12, 2018, 21 day cycles, regular; spotting between cycles x 2 yrs, onset 2015
Pap smears	Every 1-3 years, all normal except 2015 & 2016 showed endometrial cells (I was spotting)
Fibroids	Diagnosed by ultrasound: 2015, 2016 Endometrial biopsy for spotting, 2016 normal
	Status: some cramping, heavy periods, spotting between cycles, better on low carb diet

Medications & Other Treatments	*Health Providers*
Albuterol inhaler, as needed, rare use (x only need when sick)	For asthma Dr. A, MD Family Doctor
Low Dose Naltrexone 3 mg/day x Dec 2017	For ME/CFS Dr. B, MD Immunologist
Vit D 1000 mg/day; Tylenol and/or ibuprofen for cramping, abdominal pain on occasion (Dr. A)	
Bactrim : Sensitivity? Hx lightheadedness, weakness last time Rx for urinary infection (2011) (Dr. A)	
Other Treatment: Meditation 20min/day; acupuncture	For ME/CFS+ Dr. D, DAc Acupuncture
Diet: Ketogenic –meat/veggies, no sugar/dairy/fruit	For dryness, ME/CFS
	Provider C, MSN Nutritionist

Allergies

Penicillin:	Hives in childhood, Prescribed for ear infection
Latex gloves:	Hives, itching, chest tightness; Started in 2016

Social History

ACE score 3/10	Adverse childhood experiences (ACEs) increase risk for chronic illness; (see study in footer*)
Resources	Married 1995 Spouse, Friends; Painting, Reading; ME/CFS monthly Support Group
Risk Factors?	Coffee 2 cups/day Never smoked, no smokers at home; No alcohol/drug use; Seatbelts – yes
Prevention	Tetanus 2010; pneumovax 2016; mammogram normal Sept, 2016
Educn/Work	Software Engineer 1993-2002; Teacher, college 2003-2015; Part-time due to ME/CFS x 2016

Family History

Parents	Father died heart attack 43yo (1983); smoker (his father died of same in his early 40s see below)
	Mother depressed x 4 yrs after dad died, better after Prozac + therapy; low thyroid, on rx
Siblings	Younger sister (46yo) has MS, diagnosed at 37yo, stable on meds; Healthy older sister (51yo)
Grandfather	Lupus, severe (my father's Dad) onset in his 30s after WWII; died of heart attack in his 40s

* ACEs: Felitti, V. J., et al. (1998). "Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study [see comments]." American Journal of Preventive Medicine **14**(4): 245-258.

Appendix 3 - One Page Summary for Emergencies

If you would like to have information summarized for emergencies, you can create the single page document outlined below.

You can also add it to the back of a one page medical summary if you create one. I recommend it for the back of that one page form or as a separate page, since it's not actually a part of your history.

Information to include for emergencies:

- Your name and date of birth at the top of the page and the date you created this document. The date will provide some context for emergency personnel if you have had other medical events since your last update.
- Emergency contacts: names, phone numbers and any other relevant contact information
- Your doctors, their specialties, the problem you see them for and phone numbers
- Your pharmacies, with their address and phone numbers
- List of diagnoses and health problems if you don't have a one page medical summary
- Medications you are currently taking
- Medications you have had any trouble with in the past and what the problem was
- Allergies to medications, foods and other things (such as food, latex, insects etc)
    - this category is for life-threatening allergies (history of hives or other rashes, chest tightness, shortness of breath, anaphylaxis, need for epinephrine or emergency care etc)
- Brief summary of any advanced directives, such as do not resuscitate orders (have the document available so there is no miscommunication). Include the name and contact information for your lawyer if you have one who helped you draft your will or advanced directives.

Examples of places to keep your document include:

- folded up in your wallet or purse
- in the glove compartment of your car
- with other emergency supplies
- in the same place as your advanced directives, will and other important documents

Appendix 4 - If You Have Too Much for One Page

If you have one or more chronic illnesses or complex health problems, have had lots of labs and other tests, been on many medications, or had complications from surgery or other procedures, you may not be able to fit everything onto one page.

If that's the case, you can always create separate one-page summaries to supplement your one page medical summary.

These could be one-page summaries for each significant health condition you have (rheumatoid arthritis on one page, chronic fatigue on another, diabetes on a third for example).

Each page for a specific chronic illness could include:

- medications (with doses, dates, pharmacy information, the doctor who prescribed it etc) that you've tried, tested, and continue to use or discontinued for a particular diagnosis
- tests and procedures for that particular symptom or diagnosis
- details about your symptoms (when they started; what triggers them or makes them better, etc)
- other treatments you have tried or are using for that same diagnosis

If there's still too much information for a single page, then any one of these areas can have it's own separate page, such as

- one page just for lab results
- one page for all procedures
- one page for all medications.

You get the idea.

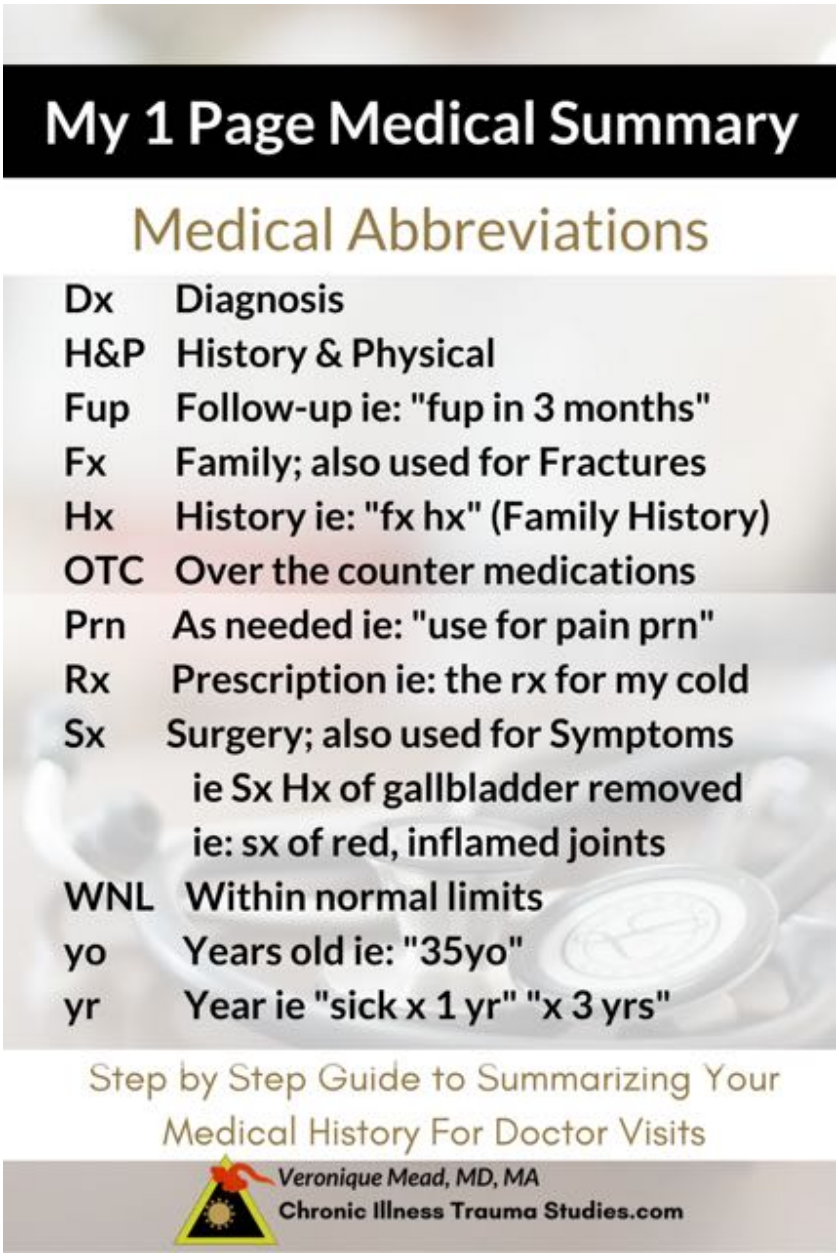
Because I have a long-standing chronic illness and other chronic symptoms, I use a one-page summary for an overview of my medical history, a second page for all lab tests and a third specifically for my chronic fatigue (ME/CFS).

The beauty of one page summaries is that you can give them to your doctor one at a time, as they get ready for more information during your evaluation. And if your doctor would rather review your chart or look at your labs on their computer, then you have this for your own reference (I bring two copies, one for the doctor and one to serve as my cheat sheet).

Sometimes doctors are better able to gather and hold onto information if they look it up in their own way or get your history directly from you (I was one of those who retained information much better when I heard it from my patients rather than from reading about it in their charts).

You can use specific one pagers for different doctors - such as the one summarizing your rheumatoid disease for your rheumatologist, the one summarizing your chronic fatigue for your new immunologist, the one summarizing your whole history for your family doctor as well as specialists.

Your summaries may vary depending on who you are seeing. This could be any number of different health care professionals, such as nurse practitioners, physician's assistants, medical students or residents in University teaching hospitals, and others. Or you may see different specialists such as endocrinology, orthopedic surgery, functional medicine, integrative medicine, a naturopath, and many more.

Once you have your summary (or summaries), you'll be able to update them in just a few minutes before new appointments.

Appendix 5 - List of Abbreviations