YOUR HEALTH DIARY

You should use this diary to:

• Learn about what questions you should ask your doctor about your treatment
• Fill in medications and other important information you should have at hand
• Share information with your family and friends who will be helping you

The health information contained in this publication is provided for educational purposes only and is not intended to replace your discussions with a healthcare professional. All decisions regarding your care must be made with a healthcare professional who can consider the unique aspects of your health.

This form is intended to provide a summary of your health care information. Keep it in a secure (safe) place and let a loved one or friend know where in case of emergency.
A Road Map to Help Manage Your Care

About atrial fibrillation, or AFib
You have been diagnosed with AFib. It occurs when 1 or both of the upper chambers (the atria) of the heart beat erratically and are out of sync with the 2 lower chambers of the heart (the ventricles). One of the biggest concerns with your diagnosis is the formation of a blood clot in your heart that can travel to your brain and cause a stroke.1

About ischemic stroke
An ischemic stroke occurs when a clot lodges in an artery supplying blood to the brain, reducing blood flow, and depriving part of the brain of oxygen and nutrients. The most important way to reduce your risk of ischemic stroke due to AFib is by reducing the chance of blood clots forming.1

Lowering your risk of ischemic stroke
By partnering with your doctor, you may be able to reduce your risk of ischemic stroke. Your doctor may decide you should take a type of blood-thinning medicine called an anticoagulant (anti-co-AG-you-lant). This type of prescription medicine helps to reduce the chance of blood clots forming by targeting certain clotting factors in your blood. Since anticoagulants lessen the ability of your blood to clot, they can increase your risk of bleeding, which can be serious and sometimes lead to death.

My Physician & Prescription Information

My primary doctor’s name:
Phone:

Other doctors I see

1 Name:
   Specialty:
   Phone:

2 Name:
   Specialty:
   Phone:

3 Name:
   Specialty:
   Phone:

I refill my prescriptions at (eg, pharmacy or mail order):
Their contact info is:
I am allergic to:

Information about my prescription benefits
Drug plan coverage:
Phone:
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<tr>
<th>Medicine name (brand name, generic name, strength)</th>
<th>This looks like</th>
<th>How many and how often</th>
<th>How I take it (eg, by mouth, with food)</th>
<th>I started taking this on</th>
<th>Why I take it</th>
<th>Who told me to take it</th>
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<p>| My Medication Diary² (cont’d.)                     |                 |                        |                                        |                          |               |                        |</p>
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| Before I go to bed, I take:                       |                 |                        |                                        |                          |               |                        |
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Adapted from the National Transitions of Care Coalition®, developed by the American Society of Health-System Pharmacists™ (ASHP) and the ASHP Research and Education Foundation™.
Some sample questions to ask your doctor

- What are the possible side effects of the medicines I am taking?
- Will any of my medications, vitamins, or supplements interact with each other?
- Am I taking my medications correctly?
- Am I taking the dose that is right for me?
- Is there anything else I need to know about my test results?
- Is there anything else I should know as it relates to my health?
- Is there anything my family or friends should be aware of as it relates to my health?
My Personal Health Record

This is the confidential Health Diary of: ________________________________

If found, please call: ________________________________________________

Emergency contact
Name: __________________________________________________________
Phone: __________________________________________________________
Relationship: ____________________________________________________


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