Installation Instructions

1. Insert disk into disk drive
2. At Program Manager pull down the file menu to Run.
3. Type a:install and press the OK button
4. Follow the on screen prompts.

Requirements

1. Windows 3.1
2. VGA graphics
3. 2 Mb RAM memory

Your Medical Records: General Features

This section of the manual describes the general display and usage features of the *Your Medical Records* program. The following areas are described:

Overview
Main Screen History Areas
Main Screen Status Line
Basic History Screen Features
Using the History Editor
Print in Progress Screen

Overview

The *Your Medical Records* program is used to enter and maintain your personal medical history, both for your own short- and long-term information and as a source for information for your physician.

The first step to be performed is to create a personal medical history (see the *File Menu* for more details). After the personal medical history is created, information is entered for each of the individual histories (see the *History Menu* for more details). When the data entry is complete, the personal medical history must be saved to disk (see the *File Menu* for more details). As the need arises to modify the entered information (e.g. - a vaccination, such as a flu shot, is updated), the saved personal medical history is loaded (*File Menu*), the appropriate histories are modified (*History Menu*), and the entry is resaved to disk (*File Menu*). The information in the personal medical history can then be printed (*File Menu*) at any time for any purpose (e.g. - for a visit to a physician).

In addition to the personal medical history maintenance features, *Your Medical Records* also provides the capability to generate a **Durable Power of Attorney** and **Living Will** (see the *Directives Menu* for more details).

Last, but definitely not least, *Your Medical Records* provides the capability to investigate the potential interactions between medications, foods which contain tyramine, nicotine, alcohol, vitamins, and caffeine (see the *Drug Interactions Menu* for more details).

Main Screen History Areas

After a personal medical history has been created or loaded, the history areas on the main screen are displayed. Each of the 14 individual histories which comprise the medical history as a whole has an area on the screen which shows the current status of the individual history. The status is comprised of two lines.

The top line shows the modification state, and is one of the following values:
Not entered - The information in the history has not been entered.
Entered - The information in the history has been entered and saved.
Modified - The information in the history has been entered but not saved.
Not applicable - The information in the history does not apply. This appears on the ObGyn history when the "Sex" selection in the Demographics history is male.

The bottom line shows the date the history was last modified. The date is automatically filled in from the current system date when the history is changed.

In addition to the current status for each history, there is a push button on the left side of each history area. Pushing and releasing the button for a history causes the appropriate screen for updating that history to be displayed.

Main Screen Status Line

At the bottom of the main screen is a status line which is comprised of three areas. The left area is an informational message bar. The messages displayed indicate what action an object on the screen is used to perform (e.g. - the File menu is used to maintain the medical history files) or what action is currently being performed (e.g. - the surgical history is being edited).

The middle area is used to display the name of the person entered in the Demographics history, if any. If there is no current personal medical history, a message is displayed in this area to that effect.

The right area is used to display the file name for the current personal medical history, if any. If a file name is displayed, the Save option under the File menu will use that name for storage of the information on disk.

Basic History Screen Features

Each of the individual history screens is composed of a set of fields unique to the particular history, plus a set of three buttons: **Done**, **Help**, and **Cancel**.

The **Done** button is used to save all changes which were made to the information on the current screen. The changes are saved in memory only; to "permanently" save the changes the Save or Save As option (see the *File Menu*) must be used.

The **Help** button is used to bring up the help section which specifically applies to the history being edited.

The **Cancel** button is used to discard all changes which were made to the information on the current screen.

Using the History Editor

Many of the 14 individual histories have an editor screen which allows additional information to be entered for that history. The operation of the history editor is the same for each history, with the only difference being the type of information entered.

The history editor has three major areas:
1) A directory which gives the names of the entries in the history and allows new entries to be added to the history.
2) A set of option buttons which define the actions which can be performed.
3) A data field section where the information for a given entry is entered/modified.

Directory Area

The directory is composed of two fields. The first field is an edit field which allows a new name to be entered and added as an entry to the editor screen. The second field is a list box that shows the names of all of the current entries, which allows an existing entry to easily be selected for modification or deletion.

To enter a new name, simply click the mouse on the edit field to make the cursor appear in the field, delete the current name in the field (if any), and type in the new name. After the name is entered, the **Add** button or the **Edit** button should be active. If the Add button is active, an entry with the same name does not exist. If the Edit button is active, an entry already exists with the same name.

To select an existing name, scroll the name into view on the list box (if it not in view already), and click the mouse on the list box entry. The name appears in the edit field and the Edit button becomes active. If the entry has been named, but has no data associated with it, the entry name is displayed with the string "(empty)" added to the front. For example, an entry with no data and the name **Eye Surgery** would appear as **(empty) Eye Surgery**. Otherwise, the name of the entry as given is displayed. All entries with data appear first in the list box (in alphabetic order), followed by all entries without data (in alphabetic order).

Option Button Area

The option buttons are used in two different ways during the course of entering information on a history editor screen.

When a new entry name is being entered or existing entry name is being selected, the option buttons have the values **Add**, **Edit**, and **Delete**. When a new name has been entered the Add button is active. Pushing the Add button causes the name to be added to the list box and starts an edit of the entry's data. At this point, the option buttons assume the values used to support the edit of data (see below). When an existing name is entered or selected from the list box, the Edit button is active, and the Delete button is active if the name is allowed to be deleted. Some of the names in the list box result from information provided on the history screen from which the editor was activated, in which case the name cannot be deleted. Pushing the Edit button starts an edit of the entry's data. Pushing the Delete button causes the entry name (and the associated data) to be deleted, given user verification of the delete.

When an entry's data is being edited, the option buttons have the values **Keep**, **Abort**, and **Clear**. Pushing the Keep button causes the current values for the data fields to be temporarily remembered and the entry edit to be terminated. Pushing the Abort button causes the current values for the data fields to be discarded and the entry edit to be terminated. In both cases, the option buttons revert to the values used to support the naming and selecting of entries for edit (see above). Pushing the Clear button causes all of the values in the data fields to be cleared (given user verification of the clear) and the edit is continued. A clear (and the subsequent entry of new data values, if any) is remembered only if the Keep button is pushed.

The Keep button, as stated, only remembers the edit temporarily. To preserve any changes beyond the editor screen, the Done button must be pushed when exiting the editor screen. If the Cancel button is pushed, all changes that were made are discarded.

Data Field Area

The data fields on a given editor screen are particular to the data requirements for the history being modified. When an entry is being edited, the edit field and list box are disabled and the data fields are active. The use of the data fields is determined by the type of each data field. For example, the Surgical History Editor has a single multiline edit field for entering data.

Note: The multiline edit fields used on the history editor screens have a built in limitation (from Windows) as to how much information can be typed into the field before it is full. This limitation is fairly large, so it is very unlikely that it will ever be encountered. However, if you ever do reach the limit, the solution is to split the information being entered into two pieces, and give each piece a name (which appears in the Directory above the multiline edit field). For example, Nephritis, Part 1 and Nephritis, Part 2, with the information split between the two entries.

Note: One way to clear the value displayed for a drop-down list field is to click on the field and press the Backspace key. This technique works for a drop-down list field on any screen, not just the history editor screens.

Print In Progress Screen

When a print is started (e.g. - to print a history or to print the results of a drug interaction analysis) the print in progress screen is displayed. It provides the detailed status for the current print, including the current page and line being printed. In addition to the status, the screen has a **Cancel** button. To abort the print, press the Cancel button. Otherwise, the screen is automatically removed from the screen when the print is complete. The font used for all print jobs (except for the wallet history print) can be specified by using the Print Font option (see the *File Menu*).

Your Medical Records: File Menu

The **File** menu provides:

1) The create, load, and save options used to maintain your personal medical history.
2) The print options used to generate the hard-copy of your personal medical history.
3) The password option used to prevent unauthorized access of your personal medical history.
4) The ability to start up/switch to Dr. Schueler's Medical Adviser (UK) CD.
5) The program exit option.

Maintaining Personal Medical Histories

The first step is the creation of your personal medical history record. To do this, pull down the **File** menu and select the **New** option, whereupon the *Demographics* history screen is displayed. You **must** enter at least your name on the Demographics screen. Push the **Done** button when you are finished entering information on the screen. The Demographics screen then disappears and the *Main Screen history areas* are displayed (assuming that you entered your name). At this point, the remainder of your personal medical history information can be entered.

If you have already created a personal medical history and saved it, the existing history file can be loaded by pulling down the **File** menu and selecting the **Open** option. The standard Windows

"Open File" dialog is displayed, allowing you to select the history file for loading. Select the history file to load, then press the **OK** button. If the selected file was saved with a password, the *Enter Password* screen is displayed and the correct password must be entered (if the wrong password is entered, the file will not be loaded). The specified file is then loaded and the *Main Screen history areas* are displayed. At this point, your personal medical history information can be modified.

If you want to save a new personal medical history, or you want to save an existing personal medical history under a new file name, pull down the **File** menu and select the **Save As** option. The standard Windows "Save File" dialog is displayed, allowing you to enter the name of the history file to be saved. It is possible to overwrite an existing history file (you must verify the overwrite). After the name is entered, push the **OK** button. If a password has been specified for the personal medical history, any subsequent loads of the history file will require correct entry of the password.

If you want to save an existing personal medical history using the same file name, pull down the **File** menu and select the **Save** option. *Your Medical Records* automatically uses the file name from which the personal medical history was loaded to save the current history information. If a password has been specified for the personal medical history, any subsequent loads of the history file will require correct entry of the password.

Printing to a Report

To print a full copy of your personal medical history, pull down the **File** menu, pull over the **Print** submenu, and select the **Normal** option. The standard Windows "Print" dialog is displayed, allowing you to define the options used to print the document. After the options are set (including checking the "Print to File" option if desired), the **OK** button is pressed. If the document is to be sent to the printer, the *Print in Progress* screen is displayed and your personal medical history is printed. If the document is to be written to a file on disk. the standard Windows "Save File" dialog is displayed, allowing you to enter the name of the output file. **Do not use the same name as your history file, as this will cause your history data to be overwritten, and thus no longer accessible to the program!**

To print a wallet-sized copy of your personal medical history, pull down the **File** menu, pull over the **Print** submenu, and select the **Wallet-size** option. The **Wallet** print user interaction screens are the same as for the **Normal** print option. The wallet print includes the following information only:

- Demographics
- Medication history
- Allergy history
- Past medical history

To select the font used to print a normal copy of your personal medical history, pull down the **File** menu, pull over the **Print Font** submenu, and select the **Normal** option. The standard Windows "Select Font" dialog is displayed. The fonts available for selection are the installed screen fonts and the installed printer fonts which are supported by the currently configured default printer. After selecting the desired font, push the **OK** button. All subsequent normal prints will use the selected font.

To select the font used to print a wallet-sized copy of your personal medical history, pull down the **File** menu, pull over the **Print Font** submenu, and select the **Wallet-size** option. The standard Windows "Select Font" dialog is displayed. The fonts available for selection are the installed screen fonts and the installed printer fonts which are supported by the currently configured default printer. After selecting the desired font, push the **OK** button. All subsequent wallet-size prints will use the selected font.

Password Protection

To add a password to your personal medical history, modify the current password, or remove the current password, pull down the **File** menu and select the **Change Password** option. The password maintenance screen is displayed. If your personal medical history has no current password, only the new password needs to be entered. To modify the current password, enter both the old password and the new password. To remove the current password, enter only the old password. After entering the necessary information, push the **Change** button. If a new password is being added, or the old password matches the current password, the change to the password is accepted. Otherwise, the password remains unchanged. **Important: If you add a password to your personal medical history, be sure you remember the password as the file can only be loaded upon correct entry of the password.**

Switching to the Dr. Schueler's Medical Adviser (UK) CD

To switch to the *Dr. Schueler's Medical Adviser (UK) CD* program, pull down the **File** menu and select the **Dr. Schueler's Medical Adviser (UK) CD** option. If Dr. Schueler's Medical Adviser (UK) CD is not running, the program is launched by *Your Medical Records*. Please remember, Dr. Schueler's Medical Adviser (UK) CD and Your Medical Records are separate programs. Once both programs are running, you must shut both programs down yourself. Shutting down Your Medical Records does not shut down Dr. Schueler's Medical Adviser (UK) CD.

Program Termination

To terminate the *Your Medical Records* program, pull down the **File** menu and select the **Exit** option.

Your Medical Records: History Menu

Your personal medical record may very well be your most important document, yet very few people have ever seen their own medical records, nor have they ever attempted to maintain their own records. Medical record keeping can be tedious and difficult. Finally, there is an easy way to keep professional-style medical information in a printable format that even your own physician will appreciate.

Virtually every physician evaluation starts with a medical history. Each time you visit the doctor he (or she) will ask you questions pertinent to your past medical history. Commonly, this will occupy the majority of your physician contact time, reducing precious time for discussion of current symptoms, or asking important questions.

Physicians appreciate patients who maintain their records and will be thankful for a printed report that outlines your medical history in a professional format. After all, important medical decisions are based on the medical history and the majority of physician diagnoses are made from this information alone!

Your Medical Records will allow you to database 14 different medical histories including:

Demographics
Medical History
Surgical History
Hospitalization History
OB-GYN History
Medication History

Allergy History
Review of Systems I
Review of Systems II
Vaccination History
Family History
Social History
Employment History
Travel History

Demographics

Enter the required information in the text field provided. Single click on a field to activate the cursor in that field. You must enter at least a name to this section to be able to create a patient file. Information concerning insurance, address, age, date-of-birth, or employment is optional. Press **DONE** to save the data and exit or press **CANCEL** to ignore any changes and exit.

The Medical History

The purpose of this section is to identify any illness/conditions you have been treated (or diagnosed with) for in the past or presently. See the ***Hospitalization History*** to identify those conditions that have required treatment "overnight" in the hospital.

On the left-hand side of the first window you will see 9 categories:

Cardiovascular
Blood Diseases
Endocrine
Kidney Disease
GenitoUrinary
Injuries
Respiratory
Cancer
Miscellaneous

When you select a category (radio button) you will be presented on the right-hand side with a menu of conditions that you may select by single clicking on the item. Single clicking on a chosen item will unselect that item. Illnesses selected from this screen will be used to formulate a list of entries within the *Medical History Editor*. Unselecting an item will remove the entry from the *Medical History Editor*, unless that entry has had additional information added using the *Medical History Editor*.

Use the *Medical History Editor* to enter additional information for each specific illness or to add a "new" illness that was not present as an earlier selection (check each category carefully). Single click on a list entry and then press the **EDIT** button to add additional information in the text field provided. After typing into the text field, press the **KEEP** button to save the data. To delete an entry, single click on the entry and press the **DELETE** button. See the section on ***Using the History Editor*** for help with adding, deleting, and editing entries.

Tips

Important additional information to add to the *Medical History Editor* would include: dates, locations, medications, treatments, diagnostic tests (and their results), and laboratory test (blood

and urine) results that apply to each illness.

Physicians are particularly interested in the results for: *EKG's*, *heart catheterization*, *cardiac stress test*, *chest x-ray*, *echocardiogram*, *upper and lower GI series*, *GI endoscopy*, and *blood tests*. If you know any of this information you should include it for later retrieval or ***printing to a report***.

The Surgical History

The purpose of this section is to database information on surgeries you have had in the past. Choose the surgical procedures that apply to you by pushing the checkbox buttons. Those surgical procedures you have chosen will appear in a list within the *Surgical History Editor*. If you unselect a checkbox, it will remove the entry from the *Surgical History Editor*, provided you have not entered additional information using the *Surgical History Editor*.

Use the *Surgical History Editor* to add a surgical procedure that does not appear as a checkbox or to provide additional information about a particular operation. Type the name of a surgical procedure in the top text field provided. Press the **ADD** button to add this to the *Surgical History Editor* list. Single click on a list entry and press the **EDIT** button to add additional information in the text field provided. Press the **KEEP** button to save this information or **CLEAR** to delete it. Press the **DONE** button to save all information and exit the editor or press **CANCEL** to exit without saving any changes.

Tips

Additional important information to add includes: dates, surgical findings, and any *post-operative complications* (e.g. - infection)

The Hospitalization History

The purpose of this section is to enter in the disease/symptoms that required "overnight" hospitalization. Press the **Select Information ...** buttons to choose conditions off a scrolling list of the data entered in the Medical History and the Surgical History. You can also enter in the specific diagnosis (or the symptom) in the field provided and press the **ADD** button to add this entry to the list. Enter in the appropriate year you were hospitalized for this problem. You may also enter the month and day (optional entries). Press the **KEEP** button to save the date. To delete an entry, single click and press the **DELETE** button. Press **DONE** to exit and save all entries or press **CANCEL** to exit without saving the information.

Tips

Even if you don't know the final diagnosis for a hospitalization, then the main symptom that lead to your hospitalization will suffice. The ***Medical History Editor*** should also include any details surrounding a hospitalization (test results, etc.).

The OB-GYN History

The *OB-GYN History* is divided into gynecological history and obstetrical history. If you have never been pregnant, there is no need to enter the obstetrical history.

On the GYN History screen choose the checkboxes that apply to you. Enter information in the text fields provided. The items chosen with a checkbox will be used to formulate a list within the

OB-GYN History Editor. Unchecking a box will delete an item off the *OB-GYN History Editor* list, provided additional information has not been entered using the *OB-GYN History Editor*. Press the **Edit Obstetrics** button to enter the OB History screen.

On the OB History screen choose the checkboxes that apply to you. Enter information in text fields provided. The items chosen with a checkbox will be used to formulate a list within the *OB-GYN History Editor*. Unchecking a box will delete an entry from this list provided no additional information was added using the *OB-GYN History Editor*.

Use the *OB-GYN History Editor* to add a new entry not found as a checkbox on either the OB or GYN history screens. Type in the text field provided and press the **ADD** button to add an entry to the list. To edit additional information on a list entry, single click on that entry and press the **EDIT** button. Now type in the text field provided and press the **KEEP** button to save the information. To delete an entry single click on the list item and press the **DELETE** button. See ***Using the History Editor*** for additional information on adding, editing, and deleting entries.

Tips

Some additional information you can add using the *OB-GYN History Editor* includes: dates, severity of symptoms, duration of symptoms, and physician treatment rendered to date. The number of times you have been treated for a particular problem, such as *pelvic inflammatory disease*, is also important.

The Medication History

The purpose of this section is to generate a list of medications you are currently using. Enter in the name (generic or trade name) of the medication in the field provided. Press the **ADD** button to include this entry on the medication list. You may also press the **Select Medications ...** button that will allow you to choose your medications from a medication list. Enter the first 1-3 letters of the medication you are looking for to quickly go to that area of the list.

After choosing your medications, edit in the strength (in milligrams or grams), dose, route, and frequency for each medication using the drop down menus provided. Press the **KEEP** button to save the edits or the **CLEAR** button to remove an edit. Single click on an entry, then press the **DELETE** button to remove it from the medication list. Press **DONE** to save all entries and exit or press **CANCEL** to exit without saving the information.

Tips

Enter in either the trade name or the generic. Look at your prescription bottles for spelling or abbreviations of medications. Proper spelling can also be found on the known medication list. The milligram strength of the medication should be entered if known. Medications you have taken in the past, and are no longer taking, should not be added to this section.

Diabetics who are taking insulin should specify the insulin type (regular or NPH) and dose (units) in the Strength field. You should leave the dosage field empty, choose subcutaneously for the route, and choose morning or afternoon for frequency.

The Allergy History

The purpose of this section is to database medications and substances that you are allergic to. Choose the medications/substances that apply to you by pushing the checkbox buttons. The selection of a checkbox button will add the item to the *Allergy History Editor* list. Unselect a

button to remove an entry from the *Allergy History Editor* list (unless you have edited additional information for this item into the *Allergy History Editor*).

Use the *Allergy History Editor* to enter in other allergies not found as a checkbox item and to add information specific to each allergy entry (see Tips below). Enter a new allergy into the field provided then press the **ADD** button to add it to the list. Single click on an entry you wish to edit and then press the **EDIT** button. Type in the field provided and press the **KEEP** button to save the edits, or the **CLEAR** button to remove the edits. Single click on an entry and press the **DELETE** button to remove an entry and it's edits. Press **DONE** to save information and exit. Press **CANCEL** to exit without saving the information. See ***Using the History Editor*** for additional information on adding and deleting information.

Tips

Include information on what type of reaction you have to a particular *allergen*. Describe your symptoms and their severity. Life-threatening reactions should be noted and are an important part of the permanent medical record.

The Review of Systems I History

The purpose of the *Review of Systems* is to identify a list of symptoms/problems you have. Problems you have had in the past, and no longer have, should not be included here. On the left-hand side of the window you will see 9 categories:

General
Nutrition
Skin
Head
Eyes
Ears, Nose and Throat
Neck
Breast
Respiratory

Choose a category by pressing the appropriate button. You will be presented with a list of items on the right-hand side of the window. Select those items which apply to you by single clicking. Unselect an item by single clicking again. Those items selected will be used to formulate a list of entries within the *Review of Systems I History Editor*. Unselecting an item will remove that item from the *Review of Systems I History Editor* unless you have edited additional information on that item using the *Review of Systems I History Editor*.

Use the *Review of Systems I History Editor* to add additional information you feel is important to each entry. You may also add additional symptoms or problems by typing in the field provided and pressing the **ADD** button. Delete an entry from the list by single clicking on the entry and pressing the **DELETE** button. Edit an entry by single clicking on an entry and pressing the **EDIT** button. Then type in the field provided. Press the **KEEP** button to save the edited information or the **CLEAR** button to remove it. See ***Using the History Editor*** for additional information on adding and deleting information.

The Review of Systems II History

The purpose of the *Review of Systems* is to identify a list of symptoms/problems you have. Problems you have had in the past and no longer have should not be included here. On the left-

hand side of the window you will see 9 categories:

Cardiovascular
Gastrointestinal
GenitoUrinary
Musculoskeletal
Neurologic
Endocrine
Immunologic
Hematologic
Psychiatric

Choose a category by pressing the appropriate button. You will be presented with a list of items on the right-hand side of the window. Select those items which apply to you by single clicking. Unselect an item by single clicking again. Those items selected will be used to formulate a list of entries within the *Review of Systems II History Editor*. Unselecting an item will remove that item from the *Review of Systems II History Editor* unless you have edited additional information on that item using the *Review of Systems II History Editor*.

Use the *Review of Systems II History Editor* to add additional information you feel is important to each entry. You may also add additional symptoms or problems by typing in the field provided and pressing the **ADD** button. Delete an entry from the list by single clicking on the entry and pressing the **DELETE** button. Edit an entry by single clicking on an entry and pressing the **EDIT** button. Then type in the field provided. Press the **KEEP** button to save the edited information or the **CLEAR** button to remove it. See ***Using the History Editor*** for additional information on adding and deleting information.

The Vaccination History

The purpose of the *Vaccination History* is to database vaccination records for all members of your family. This section also helps you track which types of vaccinations are generally given and at what times (age).

The left-hand side of the window will allow you to choose which vaccinations you (or your child) have received by pushing buttons. Notice that the *DPT*, *OPV/IPV*, *MMR*, *hepatitis B*, and *HIB* are all currently recommended childhood vaccines. The hepatitis B vaccination can also be found on the vaccine list on the right-hand side of the window. This allows for adults to enter in specific dates for immunization.

Use the vaccine list to add a "new vaccine" not present on the list or to edit in the date you received a particular vaccine. Single click on a vaccine off the list and press the **EDIT** button to enter information concerning the appropriate month, day, and year that you received that vaccine. You must at least enter in a year to make a valid entry. Press the **KEEP** button to save the information or the **CLEAR** button to delete it. Add a new vaccine by typing in the field provided and then pressing the **ADD** button. It will appear on the vaccination list (alphabetically placed). To delete an added vaccine from the list, single click on the entry and press the **DELETE** button (you cannot delete the already present vaccines from this list).

The Family History

In this section you will be able to identify illness/conditions that "run" in your family. Choose particular conditions by pressing buttons. Selected items will be used to formulate a list within the *Family History Editor*. Unselecting a checkbox will remove that entry from the *Family History*

Editor list, provided no additional data was added using the editor.

Use the *Family History Editor* to add a "new" condition/disease not listed as a checkbox. Type in the text field provided and press the **ADD** button to add a new entry to the list. To edit a list entry, single click on the item, then press the **EDIT** button. Type in additional information in the text field provided. Press the **KEEP** button to save the information or the **CLEAR** button to delete the information. Press the **DONE** button to save all your edits and exit or the **CANCEL** button to exit without saving data. See ***Using the History Editor*** for more information on adding, deleting, and editing entries.

Tips

Be sure to include information on how a relative is related to you. Include only "blood relatives." Examples include: grandmother, grandfather, mom, dad, sister or brother. If that relative died as a result of the illness in question, then this should be documented using the *Family History Editor*.

The Social History

The purpose of the *Social History* is to identify lifestyle factors that put you at risk for disease. Also included is some basic information concerning marital status and offspring. Choose the items that apply to you by pressing checkbox buttons. The items selected from this screen will be used to formulate a list within the Social History Editor. Unselecting a checkbox will remove an entry from the Social History Editor list.

Use the *Social History Editor* to add a new entry not included as a checkbox or to add additional information specific to an entry on the *Social History Editor* list. To add a new entry, type in the text field provided and press the **ADD** button. Add additional information in the text field below and press the **KEEP** button to save or the **CLEAR** button to delete. Single clicking on an entry from the list will allow you to **EDIT** or **DELETE** that entry. Press **DONE** to save the information and exit, or press **CANCEL** to exit without saving the information. See ***Using the History Editor*** for additional information on adding, deleting, or editing entries.

Tips

The sexual history is an important part of the *Social History*. Be sure to include estimates for numbers of sex partners and sexual contact with individuals from high risk groups (e.g. drug abuse history, venereal disease, homosexuality). Information on total duration (years) of use for alcohol, drugs, or tobacco) is very important.

The Employment History

The purpose of the *Employment History* is to identify occupations or exposures that put you at risk for the development of disease. Choose particular occupations by pressing buttons. Selected items will be used to formulate a list within the *Employment History Editor*. Unselecting a checkbox will remove that entry from the *Employment History Editor* list, provided no additional data was added using the editor.

Use the *Employment History Editor* to add a "new" occupation/exposure not listed as a checkbox. Type in the text field provided and press the **ADD** button to add a new entry to the list. To edit an list entry, single click on the item, then press the **EDIT** button. Type in additional information in the text field provided. Press the **KEEP** button to save the information or the **CLEAR** button to delete the information. Press the **DONE** button to save all your edits and exit or the **CANCEL** button to exit without saving data. See ***Using the History Editor*** for more information on adding,

deleting, and editing entries.

Tips

The time interval since you last held a particular job and the total time years spent at that job should be added using the *Employment History Editor*.

The Travel History

The *Travel History* is important to identify potential risks to diseases that are *endemic* to other geographical areas. You will be presented with a list of common geographical areas of interest. Choose those areas you have visited and document the length of time since you last visited. Single click on an entry, then press the **EDIT** button and choose off the list box below. Press the **KEEP** button to save a selection or the **CLEAR** button to delete a selection. You can add a new location by typing in the field provided and pressing the **ADD** button.

Tips

Diseases such as *malaria*, *salmonella*, *shigella*, *typhoid*, *encephalitis*, *hepatitis A*, *polio, meningiococcal meningitis*, *yellow fever*, *cholera*, and *rabies* are endemic in many third world countries. See the Health & Diet File in the *Dr. Schueler's Medical Adviser (UK)* for information concerning the health risks of foreign travel.

Your Medical Records: Directives Menu

Accident or illness can take away a person's ability to make health care decisions. But decisions still have to be made. If you cannot do so, someone else will; and sometimes this causes the burden, delay and expense of court proceedings. You should consider whether you want to take steps now to control these decisions so that they will reflect your own wishes.

The directives and this section of the manual provided by *Your Medical Records* are designed to provide information concerning the advance directives (*Durable Power of Attorney* and *Living Will*) relating to medical care. The directives allow the simple entry of key information, followed by the generation of the appropriate document. The generated documents are intended to demonstrate the types of information normally found in advance directives. To properly answer any questions you might have about the contents of the advance directives or other aspects of your legal situation as regards advance directives, please talk to a lawyer.

Durable Power of Attorney

If you are too sick to make decisions, close family members or a close friend usually will decide with the doctor and nurses what is best for you. And most of the time that works. But sometimes everyone doesn't agree about what to do, even if you have made a Living Will. One way to help ensure that your wishes will be honored is to name someone you trust who will make medical decisions for you. You may name this person in a Living Will (or Declaration), in which case such person makes only those medical decisions related to serious illness that could cause death.

If you want to name someone you trust to make all other medical decisions for you when you are too sick to do so yourself, you may wish to put this in writing. Remember, if you want this person to also make decisions about the use of machines and medical treatment that might delay your death when you are hopelessly ill, name the same person in your Living Will.

Should you elect to name someone to make decisions for you when your are unable to do so, you may appoint an agent to act as your attorney-in-fact by designating that person in a Durable Power of Attorney, or you may designate a person to act as a health care surrogate through the appointment of a Health Care Surrogate.

It is advisable to name a replacement in case the person you have chosen to make decisions for you becomes unable or unwilling to do so.

Living Will

A Living Will (or Declaration) is a statement of your wishes regarding the use of life-prolonging treatment if you are in a terminal condition. A "Living Will" is different from the Will which disposes of your property after your death.

Generally, a "Living Will" is a statement that you desire to be allowed to die and not be kept alive by medical treatment when your doctor(s) conclude that you are no longer able to decide matters for yourself and that condition is terminal. If you would not want to be kept alive by use of a feeding tube or other artificial means of providing food and water, specifically state this.

If you decide to make a Living Will or other advance directive, it is recommended that you give a copy to your doctor, your closest relative friend and any hospital, nursing home or other facility where you are receiving treatment or care. If you change your mind, make sure that you so advise all those to whom you have given copies.

A Living Will in no way affects life insurance. Also, it cannot be required as a condition for being insured for, or receiving, health care services. Any medical treatment that is used for the purpose of providing comfort care or to alleviate pain will be continued.

To use a Living Will:
1) Sign and date the will before two witnesses.
2) Give your doctor a copy of the will and discuss it with him/her.
3) Give copies of the will to key persons involved in your welfare. The time may come when you can no longer take part in decisions regarding your future.
4) Keep the original will easily accessible.
5) Discuss your intentions with those closest to you now.
6) Review your will once a year and redate it, initialing the new date. This clearly states your wishes are unchanged.
7) At the time of hospital admission, have a copy of the will placed in your medical record.

inteRact: The Drug Interaction Analyzer

Introduction

Welcome to *inteRact,* the first easy-to-use drug interaction analyzer. Every consumer should be fully informed before taking any medication.   Medication errors can occur for a wide variety of reasons...many of which are preventable. You, yourself, can avoid many of these problems by being as fully informed as possible with regard to your medications. *InteRact* allows you to act on this knowledge and communicate more effectively with your physician. **Remember, you are the most important member of your own health care team.**

The drug information contained in this program is largely based on current manufacturer's

packaging and drug insert information. Additional data has been compiled by the authors through personal clinical experience, pharmacological journals, and texts.

The purpose of this software is to supply the consumer with frequently needed drug information in a rapidly-accessible and easy-to-understand format.

Although great care has been taken in compiling and editing this information to ensure its accuracy and thoroughness, neither the Authors, Editors, or Publisher can be responsible for the continued currency of the information contained herein, for any errors or omissions, whether caused by negligence or otherwise, or for any consequences whatsoever arising from the use of this software. Because drug information undergoes frequent change as a result of continuing research and clinical experience, the user is to consult their physician before making any adjustments in their medications as prescribed by their physician.

Individual medications were selected in this program mainly because of their frequent clinical use; other products were added on the recommendations of the Editors and Author to make this software as complete as possible. The inclusion of a particular product in this program, however, does not imply that the Editors, Author, or Publisher endorses or recommends its use or considers it clinically superior to similar products available under other trade names.

Using inteRact

InteRact will allow you to investigate the potential interactions and effects different combinations of medications, foods that contain *tyramine*, nicotine, alcohol, vitamins, and caffeine may have in your body. Understanding potential drug interactions can help you become more aware of problems before they happen, and react more quickly to a suspected drug interaction.

You will be presented with a scrolling list of approximately 2,400 prescription and nonprescription medications. You may enter the first 1-3 characters of the medication you are looking for to advance to that area of the drug list. Choose your medications from the drug list by single clicking on the entry. Choose from the selections under *Additional Substances Used* by pushing buttons. Press the **Analyze** button to perform an analysis of all selected drugs and substances for potential interactions. The analysis results screen is then displayed. After the analysis is complete, any determined interactions are displayed. The results can also be printed by pressing the **Print** button after the results are displayed.

Drug Side Effects

Drug side effects are usually quite variable in their type and frequency of occurrence (typically 0.5-15%). Not all patients will experience the same side effects. With most medications, the majority of patients will never experience any. Occasionally, drug side effects are dose-related. This means that the risk or extent of a drug side effect is determined in part by the total quantity of the drug in the bloodstream.

Examples of common side effects seen with many medications include: fatigue, weakness, dizziness, headache, nausea, vomiting, diarrhea, and constipation. See the *Dr. Schueler's Medical Adviser (UK)* for side effect profiles specific to a particular medication.

Drug Toxic Effects (Drug Toxicity)

Drug toxicity refers to unwanted effects that occur when the level of the drug is too high in the bloodstream. Drug toxicity is dose-related. This means the severity of the toxic effect is directly

related to the level of the drug in the bloodstream.

Understanding the Types of Interactions

1. Drug A increases the effect of drug B. In this case, the therapeutic effect of drug B is increased. This can also increase the risk of drug B side effects and toxic effects.

2. Drug A can increase the toxicity of drug B. This may be secondary to drug A's ability to interfere with the body's ability to eliminate or metabolize drug B.

3. The combination of drug A and drug B can enhance sedation (sleepiness). In some patients this can be dangerous, putting them at risk for respiratory depression, or the *aspiration* of foreign material (commonly vomit) into the lung passageways (*aspiration pneumonia*).

4. The combination of drug A and drug B can increase anticholinergic effects of one (or both) drug(s). Anticholinergic toxic effects include: *paralytic ileus* (constipation and/or bloating), *urinary retention*, and increased internal eye pressure (*glaucoma*). Increasing the *anticholinergic* effect means increasing the risk of occurrence for any these effects.

5. Drug A can increase the blood level of drug B. This can result in drug B's increased therapeutic effect, but can also increase the risk of dose-related drug side effects and toxic effects.

6. The combination of drug A and drug B can increase the risk of *cardiac arrhythmias*. A cardiac arrhythmia refers to a disturbance in the rhythm (regularity) of the heartbeat. A common example would be an irregular heartbeat. Cardiac arrhythmias often manifest with complaints of palpitations, irregular pulse, faintness, or fainting.