

Keeping a Personal Wellness Record

Track medicines, supplements, symptoms, sleep, hydration, and questions for appointments.

Before you begin: This guide is for personal organization and general education. A wellness record can help you communicate patterns and questions, but it does not diagnose a condition, confirm that a medicine or supplement caused a symptom, replace a medical record, or provide emergency guidance. Do not delay urgent care while completing a tracker.

The practical rule: Record facts consistently, separate observations from conclusions, and bring the most relevant summary to the right healthcare professional.

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A record you can actually use

A useful personal wellness record is not a perfect diary of every detail. It is a current, understandable summary of information you may need between visits and during appointments.

What belongs in the record

Section	Useful details
Identity and contacts	Name, date of birth, emergency contact, key healthcare professionals, preferred pharmacy, allergies, and major conditions.
Medicines	Prescription and over-the-counter products, name, strength, form, directions, reason, prescriber, and start or stop date.
Supplements	Product and brand, ingredients, serving size, amount used, frequency, label directions, reason, and start or stop date.
Symptoms	What you noticed, start time, duration, severity, location, context, and what made it better or worse.
Sleep and hydration	Bed and wake times, awakenings, perceived rest, approximate drinks, thirst, activity, weather, and clinician-directed limits.
Appointments	Priority questions, changes, follow-up, instructions received, and next steps.

Start with a complete medicine and supplement list

The FDA recommends keeping a current list of prescription medicines, over-the-counter drugs, vitamins, and supplements. A clear list can help healthcare professionals identify duplication, interactions, possible adverse effects, and differences between what was prescribed and what is actually used.

- Copy the name, active ingredient, strength, and directions from the current label.
- Record what you actually take, including products used only as needed.
- Include eye drops, inhalers, injections, creams, patches, powders, gummies, herbals, and samples.
- Note who prescribed or recommended the product and why you use it.
- Record allergies and previous reactions separately; do not rely on memory alone.
- Do not stop, restart, or change a prescribed medicine because of something you entered in the record. Contact the prescriber or pharmacist.

Update the list whenever a product starts, stops, changes dose, changes directions, or is replaced. Review it before appointments, laboratory testing, procedures, travel, and transitions between care settings.

Track symptoms without diagnosing yourself

A symptom record can make a vague memory more specific. It cannot establish why something happened. Timing can be useful evidence, but 'after' does not automatically mean 'because of.'

Record	Example
Date and time	August 14, 3:30 p.m.
Observation	Lightheaded when standing after working outdoors.
Duration and severity	About two minutes; 4 out of 10.
Context	Warm day; lunch at noon; usual medicines taken; less fluid than usual.
Response	Sat down; symptom resolved. No fainting, chest pain, or weakness.
Question	Does this pattern need evaluation or a change in my plan?

Use plain descriptions rather than a diagnosis. 'Burning discomfort behind the breastbone for 20 minutes after dinner' is more useful than writing only 'reflux.'

Sleep: record patterns, not a score

Consumer sleep devices provide estimates, not a clinical sleep assessment. Focus on what you know and how you function.

- Time you tried to sleep and approximate wake time.
- Estimated time to fall asleep and major awakenings.
- Naps, shift work, travel, illness, pain, alcohol, caffeine, or unusual stress.
- How rested or sleepy you felt the next day.
- Snoring, witnessed breathing pauses, unusual movements, or safety concerns reported by another person.

Hydration: track context as well as volume

Hydration needs vary with food, activity, climate, illness, pregnancy, age, medicines, and health conditions. Some people have clinician-directed fluid limits. A log should not turn a general target into a personal prescription.

- Record beverages approximately; avoid chasing perfect measurement.
- Note long activity sessions, heat exposure, vomiting, diarrhea, fever, or major sweating.
- Record thirst, dry mouth, unusual swelling, dizziness, and major changes in urination when relevant.
- Follow professional guidance if you have a condition or medicine that affects fluids or electrolytes.

Prepare for appointments

A long record is not automatically a useful appointment summary. Before a visit, extract the information most relevant to that visit.

- 1 Write your top one to three questions in priority order.
- 2 Summarize what changed since the last visit.
- 3 Bring the current medicine and supplement list.
- 4 Choose a short date range that shows the pattern you want to discuss.
- 5 Bring readings or documents requested by the clinic.
- 6 Record decisions, warning signs, follow-up, testing, and who owns each next step.
- 7 Use the patient portal for routine clarification, not time-sensitive symptoms.

Use portals and official records

Your personal record and the healthcare system's record serve different purposes. Patient portals may include notes, diagnoses, medicines, immunizations, results, and instructions. Review official records for accuracy and ask the organization how to request a correction if something appears wrong.

Do not silently overwrite conflicting information. Note the discrepancy - for example, 'portal lists 10 mg; current bottle says 20 mg' - and ask the prescriber or pharmacist to reconcile it.

Protect private information

- Store paper records where household visitors cannot casually view them.
- Use device passcodes, account security features, and updates for digital records.
- Consider what an app collects, stores, and shares before using it.
- Use a secure portal rather than an unencrypted note or message when possible.
- Share only the information and access needed; use formal caregiver or proxy access when offered.
- Keep a backup you can retrieve if your phone is lost or an account becomes unavailable.

A sustainable weekly routine

Timing	Action
As changes happen	Update medicine, supplement, allergy, contact, and appointment information.
Daily, when useful	Record only symptoms, sleep, hydration, or observations related to an active question or plan.
Once a week	Look for patterns, correct incomplete entries, and write a brief summary without assigning a diagnosis.
Before an appointment	Prepare the current list, priority questions, relevant trend, and documents.
After an appointment	Record instructions, medication changes, follow-up dates, warning signs, and unresolved questions.

Keep it usable: A one-page current summary plus short, focused logs is often easier to maintain and share than a complicated tracking system. Stop collecting a data point when it no longer supports a clear purpose.

When a tracker is not enough

Seek urgent medical care for severe or rapidly worsening symptoms, chest pain or pressure, severe breathing difficulty, fainting, signs of stroke, severe allergic reaction, uncontrolled bleeding, or other emergencies. A log should never be a reason to wait. Contact a healthcare professional promptly for concerning new symptoms, suspected medicine reactions, or changes that interfere with normal activities.

References and further reading

1. FDA. [Create and Keep a Medication List for Your Health](#).
2. HealthIT.gov. [Get It, Check It, Use It: The Guide to Getting and Using Your Health Records](#).
3. AHRQ. [Safe Transitions to New Appointments](#).
4. FDA. [As You Age: You and Your Medicines](#).

Editorial note: This guide distinguishes personal observations from clinical conclusions, emphasizes accurate medicine reconciliation, and encourages focused rather than excessive self-tracking. It is general education and not medical advice.