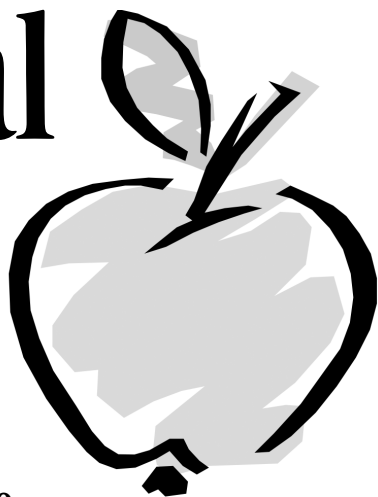


Personal Health Record



This Personal Health Record belongs to

If you have questions or concerns, contact

1) _____ () _____
Name of Primary Care Physician Phone Number

I am receiving home care services from

1) _____ () _____
Name of Home Health Agency 24-hour/7-day Phone Number

Other community services I am receiving

2) _____ () _____
Name of Service Phone Number

3) _____ () _____
Name of Service Phone Number

**REMEMBER to take this Personal Health Record
with you to all your hospital and doctor visits.**

PERSONAL INFORMATION

Address

() –
Home Phone Number

() –
Alternate Phone Number

Birth Date ____/____/____

Primary Care Physician's Name

() –
Phone Number

Other Specialty Physicians

Physician's Name

() –
Phone Number

Physician's Name

() –
Phone Number

Insurance

Pharmacy Name

() –
Phone Number

Advance Directive(s) (Check all that apply.)

Living Will Health Care Proxy DNR

Name of Health Care Proxy

() –
Phone Number

Organ Donor Yes No

CAREGIVER INFORMATION

Caregiver's Name

Relation to Patient

() – () –

Caregiver's Home Phone Number Caregiver's Alternate Phone Number

HOSPITALIZATION INFORMATION

1) Admitted ____/____/____ Discharged ____/____/____

Reason for Hospitalization _____

2) Admitted ____/____/____ Discharged ____/____/____

Reason for Hospitalization _____

3) Admitted ____/____/____ Discharged ____/____/____

Reason for Hospitalization _____

4) Admitted ____/____/____ Discharged ____/____/____

Reason for Hospitalization _____

MEDICAL HISTORY

- | | |
|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Failure |
| <input type="checkbox"/> Abnormal Heartbeat | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hip Fracture |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Hardening of the Arteries | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |

Additional Medical History

Surgeries/Dates

_____	___/___/___
_____	___/___/___
_____	___/___/___
_____	___/___/___

RED FLAGS

PERSONAL HEALTH GOAL(S)

To better manage my health and medications I will:

- Take this Personal Health Record with me to wherever I go, including ALL doctor visits and future hospitalizations.
- Call my doctor if I have questions about my medications or if I want to change how I take my medications.
- Tell my doctors about ALL of the medications I am taking, including over-the-counter drugs, vitamins and herbal formulas.
- Update the Medication Record section in this Personal Health Record with ANY changes to my medications.
- Ask questions, so I will know why I am taking each of my medications.
- Ask questions, so I will know how much, when and for how long I am to take each of my medications.
- Ask about possible medication side-effects to watch out for and what to do if I notice any.

QUESTIONS for my primary care physician _____



Improving Healthcare for the Common Good

This material was adapted from the Personal Health Record developed by Dr. Eric Coleman, UCHSC, HCPR, and prepared by IPRO, the Medicare Quality Improvement Organization for New York State, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents do not necessarily reflect CMS policy. 9SOW-NY-THM7.2-10-01