Personal Health Record

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.

THIS IS THE PERSONAL HEALTH RECORD OF

Name _____

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

Advance Directive(s) ☐ Living Will ☐ Health Care Proxy

_____ ( ) – _____

Name of Health Care Proxy Phone Number

☐ Other_____

Please Specify

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

- ☐ Arthritis
- ☐ Abnormal heart
- ☐ Cancer
- ☐ Diabetes
- ☐ Hardening of the arteries
- ☐ Heart disease
- ☐ Heart failure
- ☐ High blood pressure
- ☐ Hip fracture
- ☐ Lung disease
- ☐ Surgery (Fill in type of surgery and dates on page 5.)
- ☐ Pneumonia
- ☐ Stroke

☐ Other Diagnoses _____

_____

_____

_____

_____

_____

☐ Surgeries/Dates_____

_____

_____

_____

_____

_____

_____

_____

MEDICATION RECORD

MEDICATION NAME	DOSE	FREQUENCY

ALLERGIES_____

IMMUNIZATIONS

Influenza (Flu) Vaccine - Date Received _____/_____/_____

REASON	DATE STARTED	DATE DISCONTINUED

Pneumococcal (Pneumonia) Vaccine - Date Received _____/_____/_____

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.

NOTES for my primary care physician _____

_____

_____

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This material was 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 presented do not necessarily reflect CMS policy. 9SOW-NY-THM-7.2-08-08

IPRO Experts in Defining and Improving the Quality of Health Care