This Personal Health Record belongs to

________________________________

Community services I am receiving

<table>
<thead>
<tr>
<th>Name of Service</th>
<th>Phone Number</th>
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<tbody>
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<td>1.</td>
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</tbody>
</table>
Personal Information

Address: __________________________________________
_________________________________________________

(____) _______________ (____) _______________
Home Phone Number Alternate Phone Number

Birth Date: ____/____/_______

Primary Care Physician:

______________________________________________________________
Physician’s Name (____) ____________ Phone Number

Other Specialty Physicians:

______________________________________________________________
Physician’s Name (____) ____________ Phone Number

______________________________________________________________
Physician’s Name Phone Number

Insurance:

______________________________________________________________

Pharmacy:

______________________________________________________________
Pharmacy Name (____) ____________ Phone Number

Advance Directive(s): (Check all that apply.)
☐ Living Will ☐ Health Care Proxy ☐ DNR

Health Care Proxy:

______________________________________________________________
Name (____) ____________ Phone Number

Organ Donor: ☐ Yes ☐ No
Caregiver’s Name: _______________________________________

Relation to Patient: _______________________________________

(____) ___________________ (____) ___________________

Caregiver’s Phone Number
Caregiver’s Alternate Phone Number

Do you take care of someone?  □ Yes  □ No

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 _______________________________________
### Medication Record

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose</th>
<th>Frequency</th>
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</table>

**Allergies:**

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### Immunizations:

<table>
<thead>
<tr>
<th>Reason</th>
<th>Date Started</th>
<th>Date Discontinued</th>
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</thead>
<tbody>
<tr>
<td>Influenza (Flu) Vaccine</td>
<td></td>
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<tr>
<td>Date Received: &lt;date&gt;</td>
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<td></td>
</tr>
<tr>
<td>Pneumococcal (Pneumonia) Vaccine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date Received: &lt;date&gt;</td>
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<td></td>
</tr>
</tbody>
</table>
Medical History

- ☐ Arthritis
- ☐ Heart Failure
- ☐ Abnormal Heartbeat
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Hip Fracture
- ☐ Diabetes
- ☐ Lung Disease
- ☐ Hardening of the Arteries
- ☐ Pneumonia
- ☐ Heart Disease
- ☐ Stroke

Additional Medical History:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Surgeries/Dates:

________________________________________________________________________  ____/____/________

________________________________________________________________________  ____/____/________

________________________________________________________________________  ____/____/________

________________________________________________________________________  ____/____/________

________________________________________________________________________  ____/____/________
Health Care Information:

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

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 doctor 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

___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________

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-THM7.2-09-18