PERSONAL HEALTH RECORD

Last Updated:___/___/___

Personal Information		
Name (last)	**(first)**	**(middle/maiden)**
Current Address:		
Phone Number:		**Cell Phone:**
Date of Birth: ___/___/19___	**Place of Birth:**	
Advance Directive/Living Will: ❒Yes ❒No		**Location:**

Emergency Contact #1		
Name:	**Home Phone Number:**	**Mobile/Cell Number:**
Relationship:		**Power of Attorney:** ❒Yes ❒No
Current Address:		

Emergency Contact #2		
Name:	**Home Phone Number:**	**Mobile/Cell Number:**
Relationship:		**Power of Attorney:** ❒Yes ❒No
Current Address:		

Emergency Contact #3		
Name:	**Home Phone Number:**	**Mobile/Cell Number:**
Relationship:		**Power of Attorney:** ❒Yes ❒No
Current Address:		

Insurance Information			
Medicare #:	**Effective Date:**	❒ Part A ❒ Part B ❒ Part C ❒ Part D	
Medicaid #:	**County:**		
Private Insurance:	**Policy #:**	**Contact #:**	

Other Insurances		
Provider	**Policy Number**	**Contact Number**
1.		
2.		
3.		
4.		
5.		

Medical Provider Information	
Primary Care Physician:	**Number:**
Address	**Fax Number:**
Specialist:	**Number:**
Address	**Fax Number:**
Specialist:	**Number:**
Address	**Fax Number:**
Specialist:	**Number:**
Address	**Fax Number:**

Community Supports	
Regular Pharmacy:	**Contact Number :**
Back-Up Pharmacy:	**Contact Number:**
Home Health Agency:	**Contact Number:**
Attorney:	**Contact Number:**
Spiritual Advisor:	**Contact Number :**
Funeral Home:	**Contact Number:**

Other Important Contacts:
1.
2.
3.
4.
5.

_____

Medical History	
Medical Conditions:	**Currently Taking Medications**
	❒Yes ❒No
	❒Yes ❒No
	❒Yes ❒No
	❒Yes ❒No
	❒Yes ❒No
	❒Yes ❒No
	❒Yes ❒No
	❒Yes ❒No
	❒Yes ❒No
	❒Yes ❒No
	❒Yes ❒No
	❒Yes ❒No
	❒Yes ❒No
	❒Yes ❒No
	❒Yes ❒No
	❒Yes ❒No
Allergies:	
Negative Reactions to Medications /Treatments:	

Date of Last Flu Shot:	**Last Pneumonia Shot:**	**Tetanus Shot:**
Mammogram:	**Colonoscopy:**	**Gynecology/ Urology:**

Hospitalizations/Surgeries or In-Patient Procedures	Date and Location
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	

_____

Significant Family Health Information:

Incident Record	
Falls	**Date, Time, and Location**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Questions for my Next Medical Appointment	
Questions…	**Physician's Response…**