Personal Health Record

Reminder

Take this record with you to all your doctor visits.

Name ....

OVERLAKE Hospital Medical Center

Medical excellence every day™

Personal Information

Name: ______________________________

Address: ______________________________

Home phone: ______________________________

Birth date: ______________________________

Insurance Company and #: ______________________________

Primary Care Physician: ______________________________

Specialty Physicians: ______________________________

Caregiver/Emergency Contact

Name: ______________________________

Home phone: ______________________________

Alternate phone: ______________________________

Relationship to patient: ______________________________

Medication

- [ ] 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*** medications I am taking, including over-the-counter drugs, vitamins and herbal formulas.

- [ ] Update my medication record with any changes to my medications.

- [ ] Know why I am taking each of my medications.

- [ ] Know how much, when and how long I am to take each medication.

- [ ] Know possible medication side effects and what to do if I notice any changes.

Medication Record

List all medications, vitamins, dietary supplements and herbal preparations that you take. Keep this list updated and with you at all times. Bring it with you to all appointments, when you travel, visit a hospital or other care facility.

Home Medication Name	Dose	Route	Frequency	Purpose/ Reason for Use	Prescriber	Start Date / Stop Date	Notes
Example: Easymed	25 MG	By Mouth	Twice Daily	Blood Pressure	Dr. Jones	12/1/07 / 1/2/08	
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Date Updated:													

Allergy/Sensitivity to Drugs/Food/Environment	Describe Reaction (Symptoms, Severity)

Vaccinations

Influenza given: ____/ ____/ ____

Pneumonia given: ____/ ____/ ____

Tetanus given: ____/ ____/ ____

Patient Name: ______________________________

Medical History

Personal Medical History

Check all boxes that apply to you and your health.

- ☐ Arthritis
- ☐ Asthma
- ☐ Abnormal heart rhythm
- ☐ Bleeding/clotting disorder
- ☐ Cancer (Type) ____________________
- ☐ Diabetes
- ☐ Hardening of the arteries
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Hip fracture
- ☐ Lung disease
- ☐ Medical/surgical back conditions
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Stroke

Other diagnoses: ____

____

Family Medical History

Check all boxes that apply to your family medical history.

- ☐ Arthritis
- ☐ Abnormal heart rhythm
- ☐ Cancer
- ☐ Diabetes
- ☐ Hardening of the arteries
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Stroke

Other diagnoses: ____

____

Medical History

Hospitalization Information

Admittance date: ____/____/____/

Reason for hospitalization:

____

____

Admittance date: ____/____/____/

Reason for hospitalization:

____

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Admittance date: ____/____/____/

Reason for hospitalization:

____

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Admittance date: ____/____/____/

Reason for hospitalization:

____

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Discharge Summary

Before I leave the hospital/skilled nursing facility...

- ☐ I have been involved in deciding what will happen after I leave the hospital/skilled nursing facility.
- ☐ I understand where I am going after I leave the hospital/skilled nursing facility and what will happen when I arrive at my destination.
- ☐ I have with me the name and phone number of a person I should contact if there is a problem during my transfer.
- ☐ My family or someone close to me knows that I am coming home and what I will need.
- ☐ I have scheduled a follow-up appointment with my doctor.
- ☐ I have transportation back to my scheduled appointment.
- ☐ My doctor and or nurse has answered all of my questions.

I understand...

- ☐ What my medications are, where to get them and how to take them.
- ☐ What possible side effects may occur from my medications and who to call if I have any side effects.
- ☐ Which symptoms I need to watch for and who to call if I have any symptoms.
- ☐ My doctor or nurses' responses to all of my questions.
- ☐ How to keep my health problems from becoming worse.

My Appointment Planner
Current Medical Appointment

Appointment Date: ________________ Time: ________________ Dr. ______________________

Complete prior to visit

THINGS TO TELL MY DOCTOR:

Purpose of Visit: *(list your concerns and symptoms, starting with the most important ones)*

1. ______________________ 3. ______________________

2. ______________________ 4. ______________________

What symptoms or conditions have changed since my last visit?

____

____

How am I currently treating my symptoms or conditions?

____

____

What else is happening in my life? *(sleep problems, alcohol use, emotional stress, moved, death of a loved one, new activities, etc.)*

____

____

MY QUESTIONS: *(things to ask in priority order)*

1. ______________________ 3. ______________________

2. ______________________ 4. ______________________

Complete during visit

MY DOCTOR'S RECOMMENDATIONS: *(things to understand and do)*

____

____

New/changed medications: *(name and dosage—continue on the back of this sheet if necessary)*

______________________ ______________________

Treatments: *(e.g., appointments with other providers, exercise, heat/ice for injuries, self-care, etc.—continue on the back of this sheet if necessary)*

____

FOLLOW-UP/NEXT APPOINTMENT: ______________________________

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