

**MY PERSONAL**

**HEALTH**

**RECORD**

*Remember to take this record with you to all  
medical appointments and to the hospital.*

## To better manage my health and medications I will...

Take this Personal Health Record with me wherever I go, including all doctor visits, emergencies or to the hospital.

Call my doctor or pharmacy if I have questions about my medications.

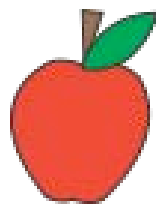
Tell my doctors and pharmacist about all pills I am taking, including over-the-counter drugs, vitamins and herbal products.

Know why I am taking each of my pills.

Know how much, when and for how long I am to take each pill.

Know possible medication side-effects to watch out for and what to do if I notice any.

Ask for help when I'm not sure about my health care goals.



***Keep this record up to date with any changes.***

## Hospital Discharge List

This is important information to know if I am in the hospital and I will complete this checklist before I leave the hospital.

- I have been involved in decisions about what will take place after I leave the hospital.
- My doctor, nurse or discharge planner has answered my most important questions prior to leaving the hospital.
- I know where I am going after I leave and what will happen to me once I arrive.
  - Discharge home to self or family
  - Discharged home with a home health agency follow up
  - Discharged to another facility for rehabilitation
- My family or someone close to me knows that I am coming home.
- I have the name and phone number of a person I should contact if a problem arises.
- I know what my pills are, how to get them, how to take them and possible side effects.
- I know how to keep my health problems from becoming worse.
- I know what symptoms I need to watch out for and whom to call if I should notice them.
- I have answers for how to get help at home when I need it.
- I have a scheduled follow up appointment with my doctor.



## Advance Directive for Healthcare

Yes     No

Where it is located: \_\_\_\_\_

Healthcare agent: \_\_\_\_\_

### Medical History

- |  |   |
|--|---|
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Hip Fracture/Replacement |
| <input type="checkbox"/> Abnormal Heart Beat | <input type="checkbox"/> Lung Disease             |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Pacemaker                |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Pneumonia                |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Stroke                   |
| <input type="checkbox"/> Heart Failure       | <input type="checkbox"/> Wound Healing Problems   |
| <input type="checkbox"/> High Blood Pressure |   |
| <input type="checkbox"/> Other _____         |   |
| <input type="checkbox"/> Other _____         |   |

### Immunizations

Annual Flu Vaccine      Date: \_\_\_ / \_\_\_ / \_\_\_

Date: \_\_\_ / \_\_\_ / \_\_\_

Date: \_\_\_ / \_\_\_ / \_\_\_

Pneumonia Vaccine      Date: \_\_\_ / \_\_\_ / \_\_\_

Other \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

Notes: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

## Notes and Questions about My Health

My health care goal (*example: I want to be able to take walks again with my dog*):

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What keeps me from meeting my health goals:

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Questions for my doctor:

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## Doctor Appointments

| Date | Doctor | Reason |
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## Hospital Information

Date Admitted: \_\_ / \_\_ / \_\_      Date Discharge: \_\_ / \_\_ / \_\_

Hospital: \_\_\_\_\_

Reason: \_\_\_\_\_

Date Admitted: \_\_ / \_\_ / \_\_      Date Discharge: \_\_ / \_\_ / \_\_

Hospital: \_\_\_\_\_

Reason: \_\_\_\_\_

Date Admitted: \_\_ / \_\_ / \_\_      Date Discharge: \_\_ / \_\_ / \_\_

Hospital: \_\_\_\_\_

Reason: \_\_\_\_\_

Every time you talk with your doctor, use the **Ask Me 3** questions to better understand your health.

- 1. What is my main problem?**
- 2. What do I need to do?**
- 3. Why is it important for me to do this?**

## Things I need to Watch for

Warning signs that my \_\_\_\_\_ condition may be getting worse:

| Warning Signs | What I need to do |
|---------------|-------------------|
|               |                   |
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|               |                   |

# My Medication List

(prescriptions, vitamins and over-the-counter)

Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

Allergies: \_\_\_\_\_

| Name                     | Dose                        | Reason     | Start Date |
|--------------------------|-----------------------------|------------|------------|
| <i>Example:</i><br>Lasix | 20 mg<br>1 a day<br>Morning | Water pill | Nov. 2007  |
|                          |                             |            |            |
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| Name | Dose | Reason | Start Date |
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