

# MEDICATION RECORD

MEDICATION NAME	DOSE	FREQUENCY

**ALLERGIES** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

REASON	DATE STARTED	DATE DISCONTINUED

**IMMUNIZATIONS**  
Influenza (Flu) Vaccine - Date Received \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Pneumococcal (Pneumonia) Vaccine - Date Received \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

## MEDICAL HISTORY

- |  |  |
|--|--|
| <input type="checkbox"/> Arthritis                 | <input type="checkbox"/> Heart Failure       |
| <input type="checkbox"/> Abnormal Heartbeat        | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Hip Fracture        |
| <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Lung Disease        |
| <input type="checkbox"/> Hardening of the Arteries | <input type="checkbox"/> Pneumonia           |
| <input type="checkbox"/> Heart Disease             | <input type="checkbox"/> Stroke              |

### Additional Medical History

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### Surgeries/Dates

_____	____/____/____
_____	____/____/____
_____	____/____/____
_____	____/____/____

## 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 \_\_\_\_\_  
\_\_\_\_\_

## 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

### Insurance

Pharmacy Name

Phone Number

**Advance Directive(s)** (Check all that apply.)

Living Will    Health Care Proxy    DNR

Name of Health Care Proxy

Phone Number

Organ Donor    Yes    No

## RED FLAGS

### 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 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.

## 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. 1050W-NY-AIM8-13-06

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# Personal Health Record

This Personal Health Record belongs to \_\_\_\_\_

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.**



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