MEDICATION RECORD

MEDICATION NAME	DOSE	FREQUENCY

REASON	DATE STARTED	DATE DISCONTINUED

ALLERGIES_____

_____

_____

IMMUNIZATIONS

Influenza (Flu) Vaccine - Date Received _____/_____/_____

Pneumococcal (Pneumonia) Vaccine - Date Received _____/_____/_____

MEDICAL HISTORY

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

Additional Medical History

_____

_____

_____

_____

_____

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 _____

Quality Improvement Organizations
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CENTERS FOR MEDICARE & MEDICAID SERVICES

IPRO

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. 10SOW-NY-AIM8-13-06

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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