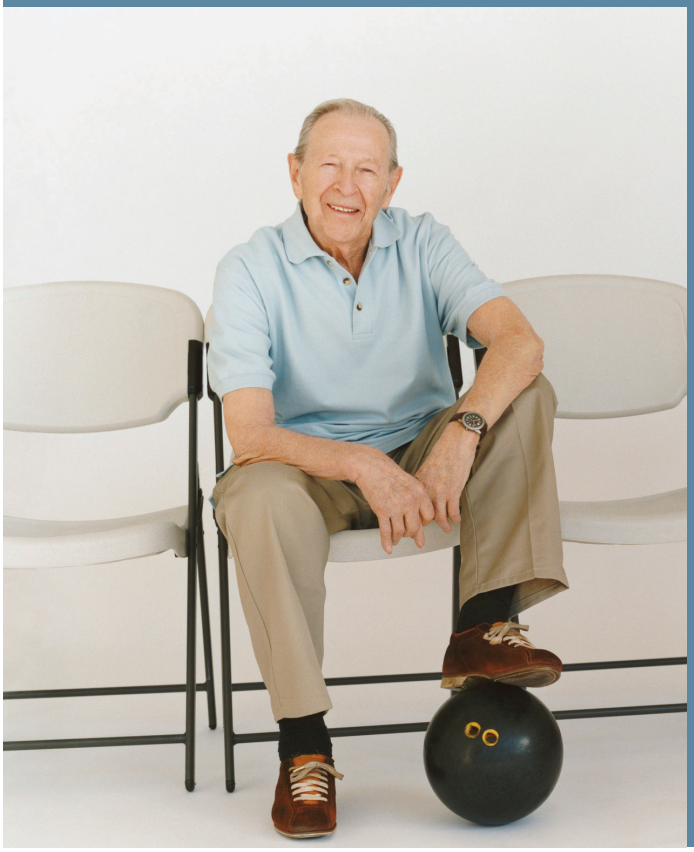
Personal Health Record



Reminder

Take this record with you to all your doctor visits.

Name .....

OVERLAKE Hospital Medical Center

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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	

Date Updated:													

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

Vaccinations

Influenza given: ____/ ____/ ____

Pneumonia given: ____/ ____/ ____

Tetanus given: ____/ ____/ ____

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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:

_____

_____

Admittance date: ____/____/____/

Reason for hospitalization:

_____

_____

Admittance date: ____/____/____/

Reason for hospitalization:

_____

_____

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.

Rx for Communication®
working effectively with your doctor

My Appointment Planner
Current Medical Appointment

Appointment Date: _____ Time: _____ Dr. _____

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. _____

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: _____

Complete prior to visit

Complete during visit