

Personal Health Record

(for your wallet)

Name _____

Date of Birth _____

Doctor _____

Doctor's phone _____

Emergency Contact

Name _____

Phone _____

My Health Conditions Include:

- | | |
|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Joint replacement |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Contact lenses |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Dentures/partial |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Lung problems | <input type="checkbox"/> Defibrillator |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Hearing aid |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Kidney problems | |

Advance Directives I have completed:

- | |
|---|
| <input type="checkbox"/> Living Will |
| <input type="checkbox"/> Durable Power of Attorney for Healthcare |
| <input type="checkbox"/> Neither |

Past Surgeries

	Year

Immunization dates

Flu _____

Tetanus _____ Pneumonia _____

Medication Matters!

Update this card and keep it with you at all times. Remember to ask your doctor or pharmacist:

1. What is the name of the drug and what is it supposed to do?
2. How and when do I take it and for how long?
3. What foods, drinks, other medicines and activities should I avoid while taking this drug?
4. Are there any side effects? What do I do if they occur?
5. Is there written information available about the drug?



Allergies (Medications, Foods, Latex, other)

Allergies (Medications, Foods, Latex, other)	Reaction

Medical Insurance and Pharmacy

Primary Med Insurance name _____
Number _____
Secondary name/number _____
Primary pharmacy _____
Pharmacy phone _____