



# PERSONAL HEALTH RECORD

**Take this health record to ALL doctor and hospital visits.**

Name:	
Date of Birth:	
Allergies to Medication:	
Pharmacy Name:	
Pharmacy Phone Number:	

## EMERGENCY CONTACT INFORMATION

	NAME	RELATIONSHIP	PHONE NUMBER
1			
2			
3			

## PHYSICIAN INFORMATION

SPECIALTY/TYPE OF DOCTOR	NAME	PHONE NUMBER
Primary Care Physician (PCP)		

## HEALTH PLAN CONTACT INFORMATION

	DESCRIPTION	PHONE NUMBER
1	Customer Service	
2	Case Manager Name: _____	
3		

**HEALTH HISTORY AND RED FLAGS**

HEALTH CONDITIONS	
1	
2	
3	
4	
5	

RED FLAGS	ACTION

QUESTIONS FOR YOUR DOCTOR	
1	
2	
3	
4	
5	
6	

Next scheduled PCP visit (date and time): \_\_\_\_\_

Next scheduled Specialist visit (date and time): \_\_\_\_\_

PERSONAL GOALS	
1	
2	
3	
4	
5	

**MEDICATION RECORD**

- Tell your doctor about ALL medications that you are taking, including over-the-counter drugs, vitamins and herbal formulas.
- Update this Medication Record every time there is a change in the medications you are taking.
- Know the reason you take each medication, and how much, when and for how long to take each medication.
- Know possible medication side effects and understand what to do if you have side effects.
- Call your doctor if you have questions about your medications or if you want to change how you take your medications.

	MEDICATION NAME (include over-the-counter)	DOSE mg/mcg/cc	FREQUENCY (ex: 1X/day, 2X/day, every other day)	REASON FOR TAKING MEDICATION
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				