Personal Health Record

Quality Improvement Organizations
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CENTERS FOR MEDICARE & MEDICAID SERVICES

Qsource

This is the Personal Health Record of:

_____

Your Name

If you have questions or concerns, contact:

_____

Contact Name

at _____.

Phone Number

Personal Information

Address: _____

_____

Home Phone: _____

Alternate Phone: _____

Birth Date: _____

Advance Directive/Living Will? ☐ Yes ☐ No

If yes, where is it located? _____

Caregiver Information

Name: _____

Relationship: _____

Home Phone: _____

Alternate Phone: _____

Provider Information

Primary Care Doctor: _____

Phone: _____

Pharmacy: _____

Phone: _____

Other Providers:

_____

_____

_____

_____

REMEMBER to take this record with you to all your doctor visits!

Medication & Supplement Record

Name	Dose	Reason	New
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Medication Allergies

Medication & Supplement Record

Name	Dose	Reason	New
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Medication Allergies

To better manage my health and medications, I will...

- Take this Pesonal Health Record with me 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** 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 for how long I am to take each medication.
- Know possible medication side effects to watch out for and what to do if I notice any.

Medical History & Red Flags

Discharge Checklist

Before I leave the care facility, the following tasks should be completed:

- ☑ I have been involved in decisions about what will take place after I leave the facility.
- ☑ I understand where I am going after I leave this facility and what will happen to me once I arrive at a new facility.
- ☑ I have the name and phone number of a person I should contact if a problem arises during my transfer.
- ☑ I understand what my medications are, how to obtain them and how to take them.
- ☑ I understand the potential side effects of my medications and who I should call if I experience them.
- ☑ I understand what symptoms I need to watch out for and who to call should I notice them.
- ☑ I understand how to keep my health problems from becoming worse.

- [ ] My doctor or nurse has answered my most important questions prior to leaving the facility.

- [ ] My family or someone close to me knows that I am coming home and what I will need once I leave the facility.

- [ ] If I am going directly home, I have scheduled a follow-up appointment with my doctor and I have transportation to this appointment.

Personal Goal

_____

_____

_____

_____

_____

_____

_____

_____

Notes for my Primary Care Doctor

Recent Hospitalization

Admitted Date: _____/_____/_____

Discharge Date: _____/_____/_____

Reason for Hospitalization

_____

_____

_____

_____

_____

Questions for my Primary Care Doctor

live. well.

STAT
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