Personal Health Record

Last name:

Date form completed	By Whom	Revised	Initials

Name:	**Birth date:** **Nickname:**	☐ Adv. Directives ☐ Self Guardian
Home Address:	**Home/Work Phone:**	
Parent/Guardian:	**Emergency Contact Names & Relationship:**	
Signature/Consent:		
Ht: **Wt:** **Blood Type:**	**How I Communicate:**	
Primary Language:	**Phone Number(s):**	

Physicians:

Primary care physician:	**Emergency Phone:** **Fax:**
Current Specialty physician: **Specialty:**	**Emergency Phone:** **Fax:**
Current Specialty physician: **Specialty:**	**Emergency Phone:** **Fax:**
Dentist:	**Emergency Phone:**
Anticipated Primary ED:	**Pharmacy:**

Anticipated Tertiary Care Center: ☐ Queens ☐ Kaiser ☐ Tripler ☐ Kapiolani ☐ Straub ☐ St. Francis

Current or Active Conditions:

1.

2.

3.

4.

Synopsis:

Baseline physical findings:

Baseline vital signs:

Baseline neurological status:

Last name: _____

Medical History:

AIDS		Headaches		Palpitations	
Arthritis		Hearing Impairment		Periods of Unconsciousness	
Asthma		Heart Condition		Rheumatic Fever	
Bronchitis		Hemodialysis		Rheumatism	
Cancer		Hepatitis		Seizures	
Chest Pain/Pressure		High Blood Cholesterol		Shortness of Breath	
Diabetes		High Blood Pressure		Stomach, Liver or Intestinal Problems	
Dizziness		HIV Positive			
Emphysema		Hypoglycemia		Thyroid Problems	
Epilepsy		Jaundice		Tuberculosis	
Eye Problem		Kidney Disease		Tumor	
Fainting		Low Blood Pressure		Urinary Tract Infection	
Glaucoma		Mental Retardation		Smoking / packs per day:	
STD: ☐ Chlamydia ☐ Herpes ☐ Gonorrhea ☐ Syphilis				number of years:	

Immunizations (mm/yy)

Dates							Dates					
DPT							Hep A					
OPV/IPV							Hep B					
MMR							MEN					
HIB							PNU					
HPV							TB status					
Influenza							Varicella					
Rotavirus							Other					
Other							Other					

Antibiotic prophylaxis: Indication: Medication and dose:

General Management Data:

Allergies: Medications/Foods to be avoided	**and why:**
1.	
2.	
3.	
Procedures to be avoided	**and why:**
1.	
2.	
3.	
Best interventions to be used	
1.	
2.	
3.	

Last name:

Nutritional Accommodations:

Dates		Dates	

Medications/Appliances:

Medications: Use of Medication:	Prostheses/Appliances/AssistiveTechnology Devices:
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Behaviors and Communication:

Last name: _____

Health Log: (Non-infectious major illnesses, special tests, x-rays, hospitalizations, surgeries, etc.)

Dates		Dates	

Special Health Care Needs with Specific Suggested Management

Problem	Treatment Considerations

☐ See Emergency Action Plan

Comments on family or other specific medical issues:

Physician/Provider Signature: **Print Name:**

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