

*My Personal Health Record
book provided by the
Area Agency on Aging
of Southwest Arkansas, Inc.*



MY PERSONAL
**HEALTH
RECORD**

600 Lelia Street | Magnolia
agewithdignity.com
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*This tool will help me organize
my ongoing health plan.*

Date Completed:

TO BETTER MANAGE MY HEALTH AND MEDICATIONS I WILL ...

- Take this Personal Health Record with me wherever I go, including all doctor visits, emergencies or hospitalizations.
- Call my doctor or pharmacist if I have questions about my medications,
- Tell my doctors and pharmacists about all medications I am taking, including over-the-counter drugs, vitamins and herbal formulas.
- 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.
- Ask for help when I'm uncertain about my healthcare goals.
- Keep this record up to date if anything changes.

Hospital Discharge List

This is important information to know if I am hospitalized and I will complete this checklist before I leave the hospital.

- I have been involved in decisions about what will take place after I leave the hospital.
- My doctor, nurse or discharge planner has answered my most important questions prior to leaving the hospital.
- I understand where I am going after I leave and what will happen to me once I arrive.
 - Discharged home by myself or with my caregiver
 - Discharged home with a home health agency follow up
 - Discharged to another facility for rehabilitation
- My caregiver or someone close to me knows that I am coming home.
- I have the name and phone number of a person I should contact if a problem arises.
- I understand what my medications are, how to get them, how to take them, and possible side effects.
- I understand what symptoms I need to watch out for and whom to call if I should notice them.
- I have answers for how to get help at home when I need it.
- I have a scheduled follow-up appointment with my doctor.

Hospitalization/Emergency Room Information

Date Admitted: _____

Hospital: _____

Reason: _____

Date Admitted: _____

Hospital: _____

Reason: _____

Date Admitted: _____

Hospital: _____

Reason: _____

Date Admitted: _____

Hospital: _____

Reason: _____

Personal Health Record

Name: _____ Birth Date: ___/___/___

Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Emergency Contact

Primary person who helps me manage at home:

Name: _____ Phone: _____

Relationship: _____

Others:

Name: _____ Phone: _____

Relationship: _____

Name: _____ Phone: _____

Relationship: _____

Name: _____ Phone: _____

Relationship: _____

Medicare

Medicare #: _____

Part A Start Date: _____ Part B Start Date: _____

Part D Provider: _____ ID #: _____

Supplement

Provider: _____

ID#: _____ Provider Phone: _____

Doctors

Primary Doctor: _____ Phone: _____

Specialist: _____ Phone: _____

Specialist: _____ Phone: _____

Specialist: _____ Phone: _____

Specialist: _____ Phone: _____

Other Healthcare Resources

Pharmacy: _____ Phone: _____

Home Health Agency: _____ Phone: _____

Community Services: _____ Phone: _____

(Examples: Meals on Wheels, personal care or transportation services)

When to get a 2nd Opinion

Ten Reasons to get a Second Opinion


1. When you are told you need an invasive procedure or surgery.
2. You have a rare or complex condition.
3. You are told there is only one way to treat your problem.
4. You are told there is only one doctor who can help you.
5. You have multiple medical issues that put you at risk for anesthesia.
6. Your doctor has recommended a controversial or experimental treatment, perhaps one that is not covered by insurance.
7. You are guaranteed glowing results or told there is no risk involved in a procedure.
8. You don't have confidence your doctor or surgeon has treated enough cases like yours.
9. You aren't comfortable proceeding with your doctor's approach for you.
10. The treatment you received isn't producing the results you or your physician expected.

When to Stop Getting Opinions

When you have a medical emergency and immediate treatment is advised.

When you have consulted several physicians and surgeons for a non-controversial problem, but are still not comfortable proceeding.

My Medications (prescriptions, vitamins, and over-the-counter medications)

Drug Name (brand/generic name)	Why am I taking this medicine?	Medicine Appearance and Amount
 IN THE EVENING, I TAKE:		

Notes and Questions About My Health

My healthcare goal (example: *I want to be able to take walks again with my dog*):

What keeps me from meeting my health goals:

Questions for my doctor:

Things I Need to Watch For

Warning signs that my _____ condition may be getting worse.

WARNING SIGNS

WHAT I NEED TO DO

Date Completed: _____

How many or how much do I take?	How do I take this medicine?	Start Date	Stop Date	Prescribed by

My Medications (prescriptions, vitamins, and over-the-counter medications)

Drug Name (brand/generic name)	Why am I taking this medicine?	Medicine Appearance and Amount
 IN THE AFTERNOON, I TAKE:		

Before you leave the pharmacy, be sure to:

- Make sure the label has your name on it.
- Make sure you can read and understand the directions on the bottle.
- Make sure the directions are the same as your doctor said. If not, tell the pharmacist.
- Ask for an easy-open cap if you have trouble opening the bottle. Be sure to keep all medicines out of reach of children.
- Find out if the medicine needs to be stored in a special place, such as the refrigerator.
- Should I take this medicine with food? Is there anything I should not eat or drink when taking this medicine?
- Is there a generic (non-brand name) version of the drug I can take?
- Is it safe for me to drive while taking this medicine?
- What does “as needed” mean?



How to read your medicine label

Pharmacy name and address: Local Pharmacy, 123 MAIN STREET, ANYTOWN, USA 11111, (800) 555-5555

Doctor's name: DR. C. JONES

Drugstore phone number: (800) 555-5555

Prescription fill date: DATE 06/23/18

Person who gets this drug: JANE SMITH, 456 MAIN STREET ANYTOWN, US 11111

Instructions about how often and when to take this drug: TAKE ONE CAPSULE BY MOUTH THREE TIMES DAILY FOR 10 DAYS UNTIL ALL TAKEN

Name of drug and strength of drug: AMOXICILLIN 500MG CAPSULES

Number of refills before certain date: QTY NO REFILLS - DR. AUTHORIZATION REQUIRED, MRG, USE BEFORE 06/23/18, SLF/SLF

Don't use this drug past this date: USE BEFORE 06/23/18

Other information: NO 0060023-082981, SPECIAL INSTRUCTIONS © 2017

Sample prescription label found on www.arkansasbluecross.com

All prescription medication labels may not include all the information above. Some labels may have a different layout than the one shown. If you have any questions, ask the pharmacist or your doctor.

