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



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HEALTH RECORD

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:	
<b>Emergency Contact</b>	
Primary person who helps me manage	e at home:
Name:	Phone:
Relationship:	
Others:	
Name:	Phone:
Relationship:	
Name:	Phone:
Relationship:	
Name:	
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:
Other Healthcare Resou	urces
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 Blood Pressure, Blood Glucose and Weight

# DATE BLOOD PRESSURE BLOOD GLUCOSE WEIGHT

#### **Medical History**

☐ Arthritis	☐ Hip Fracture/Replacement
Cancer	Lung Disease
☐ COPD	Osteoporosis
☐ Diabetes	☐ Pacemaker
☐ Heart Disease	Pneumonia
☐ Heart Failure	Stroke
☐ High Blood Pressure	☐ Tuberculosis
☐ High Cholesterol	☐ Wound Healing Problems
Other:	
Other:	
Other:	
☐ Other:	
I have or have had problems with.	
I have or have had problems with:	
Balance/Walking	☐ Memory
☐ Balance/Walking ☐ Falls	Pain
☐ Balance/Walking ☐ Falls ☐ Incontinence	Pain Vision
☐ Balance/Walking ☐ Falls ☐ Incontinence ☐ Hearing	Pain
☐ Balance/Walking ☐ Falls ☐ Incontinence	Pain Vision
☐ Balance/Walking ☐ Falls ☐ Incontinence ☐ Hearing	Pain Vision Weight
☐ Balance/Walking ☐ Falls ☐ Incontinence ☐ Hearing ☐ Mental Health	Pain Vision Weight
☐ Balance/Walking ☐ Falls ☐ Incontinence ☐ Hearing ☐ Mental Health ☐ Other:	Pain Vision Weight

Meai	cal History cont	inuea
Childho	ood Illnesses	
<ul><li>☐ Measles</li><li>☐ Mumps</li><li>☐ Rubella</li></ul>		<ul><li>☐ Chickenpox</li><li>☐ Rheumatic Fever</li><li>☐ Polio</li></ul>
Surge	ries	
Year	Reason	Hospital/Dr
	nizations  Vaccine: / /	_ Last Tetanus Shot://
		_/ Meningococcal:/
C	is A:/ Hep	Č
-	_	e Vaccine (PPSV23)://
	•	ccine (PCV13:/
	Ieasles, Mumps, Rube	
	•	,// Brand:
	9 Rooster:	

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
OTHER MEDICATIONS, THAT I DO N	OT USE EVERY DAY:	
ALLERGIES THAT I NEED TO BE AW	ARE OE:	
ALLERGIES HIAI INCLUDIO DE AW	ANL OI.	

#### Preventative services covered under Medicare Part-B

Did you know that Medicare Part B includes a "Welcome to Medicare" preventive visit along with a host of other preventative services?

During the first 12 months that you have Part B, you can get a "Welcome to Medicare" preventive visit. The visit includes a review of your medical and social history related to your health. It also includes education and counseling about preventive services, including certain screenings, shots or vaccines (like flu, pneumococcal, and other recommended shots or vaccines), and referrals for other care, if needed. When you make your appointment, let your doctor's office know that you'd like to schedule your "Welcome to Medicare" preventive visit. You pay nothing for the "Welcome to Medicare" preventive visit if the doctor or other qualified health care provider accepts assignment.

#### Other services Include:

- Yearly "Wellness" visit
- · Abdominal aortic aneurysm screening
- Alcohol misuse screening & counseling
- Bone mass measurement (bone density)
- Breast cancer screening (mammogram)
- Cardiovascular disease (behavioral therapy)
- Cardiovascular disease screenings
- Cervical & vaginal cancer screenings
- Colorectal cancer screenings
- Counseling to prevent tobacco use & tobacco-caused disease
- Depression screening
- Diabetes Prevention Program
- Diabetes screenings
- Diabetes self-management training
- Flu shots
- Glaucoma tests
- Hepatitis B shots
- Hepatitis B Virus infection screening
- Hepatitis C screening test
- HIV (Human Immunodeficiency Virus) screening
- Lung cancer screening
- Obesity screening & counseling
- Pneumococcal shots
- Prostate cancer screenings
- Sexually transmitted infection screening & counseling

For more information on these and other medicare services, go to medicare.gov or download the 'What's covered' app.

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Last Eye Exam:/ Colonoscopy:/				
Physical:/ Stress test://				
Mammogram:/ Prostate exam:/	_/	-		
Other:	_;	_/	_/	
Other:	:	/	/	

#### **Doctor Appointments**

DATE	TIME	DOCTOR	REASON
$\vdash$			

Date Completed:

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

#### $\begin{tabular}{ll} My\ Medications \ (prescriptions, vitamins, and over-the-counter medications) \end{tabular}$

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

#### Notes and Questions About My Health

What keeps me from meeting my health goals:
Questions for my doctor:

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Varning signs that my	condition may be getting worse.
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WARNING SIGNS	WHAT I NEED TO DO

Date Completed: _	
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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 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?



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.

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Date Completed:

Drug Name (brand/generic name)	Why am I taking this medicine?	Medicine Appearance and Amount	How many or how much do I take?	How do I take this medicine?	Start Date	Stop Date	Prescribed by
WHEN I GET UP, ITAKE:							