

Do your

PART

I will “Do My Part” and Take Charge of My Health.

I will fill this out and...

- Take this Personal Health Record with me to all medical appointments, hospitalizations and when I travel.
- Bring all medications to every doctor’s visit.
- Complete a “Living Will” and have a “Power of Attorney” for my health care.
- Use “Ask Me 3” questions every time I talk to my doctor:
 1. What is my main problem?
 2. What do I need to do?
 3. Why is it important for me to do this?
- Exercise regularly.
- Eat healthy.



Personal Health Record of:

Name: _____ Birth Date: ___ / ___ / ___

Address: _____

Phone: _____

Email: _____

Emergency Contacts

Name: _____ Phone: _____

Relationship: _____ Alt. Phone: _____

Name: _____ Phone: _____

Relationship: _____ Alt. Phone: _____

Doctors and Pharmacy

Primary Doctor: _____ Phone: _____

Specialist: _____ Phone: _____

Specialist: _____ Phone: _____

Pharmacy: _____ Phone: _____

Others who provide care for me

Home Health Agency: _____ Phone: _____

Community Services: _____ Phone: _____

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

My Hospital: _____

Notes and Questions about My Health

My health care 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:

Medical History

- | | | |
|--------------------------------------|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Asthma/COPD | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis/HIV | <input type="checkbox"/> Ulcer |
| Type: _____ | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizure |

- Surgeries (such as cataract, joint replacement, fracture, heart by-pass, gall bladder, hysterectomy, prostate, pacemaker, defibrillator)

Surgery: _____ Date: __/__/__

Surgery: _____ Date: __/__/__

Surgery: _____ Date: __/__/__

Surgery: _____ Date: __/__/__

Surgery: _____ Date: __/__/__

Surgery: _____ Date: __/__/__

Surgery: _____ Date: __/__/__

Immunizations & Screenings

Annual Flu Vaccine Date: __/__/__ __/__/__ __/__/__

Pneumonia Vaccine Date: __/__/__

Mammogram Date: __/__/__ __/__/__ __/__/__

Colorectal Screening Date: __/__/__ __/__/__ __/__/__

Prostate Screening Date: __/__/__ __/__/__ __/__/__

Cholesterol Screening Date: __/__/__ __/__/__ __/__/__

Blood Sugar Screening Date: __/__/__ __/__/__ __/__/__

Notes: _____

Hospital Visits

Date Admitted __/__/__ Date Discharged __/__/__

Hospital: _____

Reason: _____

Date Admitted __/__/__ Date Discharged __/__/__

Hospital: _____

Reason: _____

Date Admitted __/__/__ Date Discharged __/__/__

Hospital: _____

Reason _____

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Hospital: _____

Reason: _____

Things I Need to Watch For

Warning signs that my medical condition may be getting worse:

Warning Signs	What I need to do

My Medication List (including prescriptions, vitamins and over-the-counter medicines)

Allergies: _____

Name of Medication	How much? When?	What is it for?	Start Date
Example: Lasix	20 mg 1 a day morning	Water pill	Nov 2011

Cross out medications that you are no longer taking.

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Hospital Checklist

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 case manager has answered my most important questions prior to leaving the hospital.
- I understand where I am going after I leave the hospital and what will happen to me once I arrive:
 - Home alone or with family
 - Home with a home health agency follow-up
 - At another facility for more treatment
- My family 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 how to keep my health problems from becoming worse.
- I understand which warning signs 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.



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Organizations**

Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES