

**MY PERSONAL HEALTH RECORD**

name \_\_\_\_\_

date of birth \_\_\_\_\_

phone number \_\_\_\_\_

address \_\_\_\_\_

insurance \_\_\_\_\_

preferred pronouns \_\_\_\_\_

PCP \_\_\_\_\_

PCP phone number \_\_\_\_\_

emergency contact \_\_\_\_\_

emergency contact phone \_\_\_\_\_

date updated \_\_\_\_\_

***ALLERGIES? IF NONE CIRCLE NKA IF YES, LIST BELOW***

allergen	reaction	allergen	reaction

*past medical history/complete diagnosis list*

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*past surgical procedures*

surgical procedure	date	reason	surgeon	hospital

*past hospital stays*

hospital stay	date	reason	hospital

*vaccinations*

vaccination	date received	vaccination	date received	vaccination	date received
pneumococcal		covid		hepatitis B	
chicken pox		MMR		DTap	
hpv		TDAP		rotavirus	
shingles		polio		Flu	
flu		menB		Other	

**current medication list** (includes all medications, prescription and over the counter, inhalers, suppositories, inhalers, topical ointments and creams)

medication	dose	frequency	started	ended	reason

pharmacy/phone number \_\_\_\_\_

*other treatments including wound care, prosthetic use, etc.*

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*advance directive forms, healthcare proxy forms, DPOA, parental agreements (attach copies)*

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CareAline®

*doctors and other specialists*

doctor	specialty	number	on-call number	email

*friends and family allowed personal information*

name	phone number/email	health care proxy?