



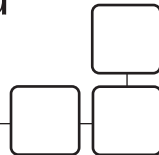
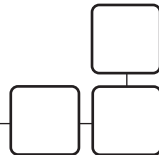
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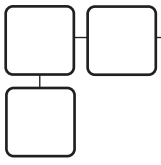
Personal Health Record of:

(NAME)

If you have questions or concerns,
contact _____
at (_____) _____ - _____

REMEMBER to take this record
with you to all doctor visits





Personal Information

Family Caregiver Information

Name: _____

Relation to Patient: _____

Phone #: _____

Alternate Phone #: _____

In what ways do your caregivers help you manage your conditions?

Advance Directive / Living Will:

NO YES Where can this be found?

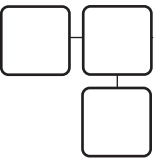
Health Care Provider Information

Primary Care Dr.: _____

Phone #: _____

Pharmacy: _____

Other Providers: _____

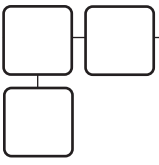


Questions for other Providers:

Pharmacist

Case Manager

Other (list name, specialty, organization)

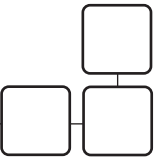


Questions for my Primary Care Doctor:

My Health Conditions

Red Flags

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____





Personal Goal

Notes:





Allergies



Medication Record

