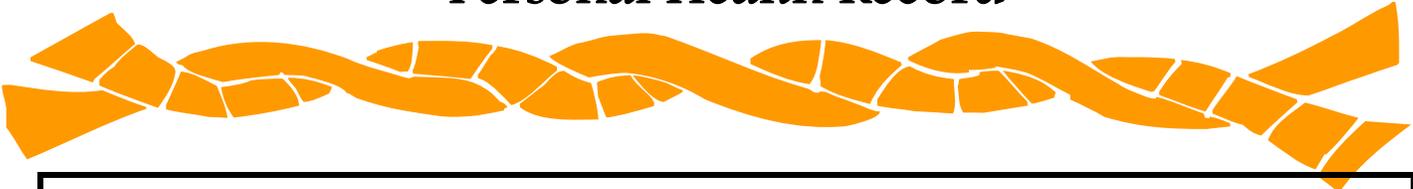


Personal Health Record

Last name:



Date form completed	By Whom	Revised	Initials
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Name:	Birth date:	Nickname:	<input type="checkbox"/> Adv. Directives <input type="checkbox"/> Self Guardian
Home Address:		Home/Work Phone:	
Parent/Guardian:		Emergency Contact Names & Relationship:	
Signature/Consent:			
Ht:	Wt:	Blood Type:	How I Communicate:
Primary Language:		Phone Number(s):	
Physicians:			
Primary care physician:		Emergency Phone:	
		Fax:	
Current Specialty physician:		Emergency Phone:	
Specialty:		Fax:	
Current Specialty physician:		Emergency Phone:	
Specialty:		Fax:	
Dentist:		Emergency Phone:	
Anticipated Primary ED:		Pharmacy:	
Anticipated Tertiary Care Center: <input type="checkbox"/> Queens <input type="checkbox"/> Kaiser <input type="checkbox"/> Tripler <input type="checkbox"/> Kapiolani <input type="checkbox"/> Straub <input type="checkbox"/> St. Francis			

Current or Active Conditions:	
1. _____	Baseline physical findings: _____
_____	_____
2. _____	_____
_____	_____
3. _____	Baseline vital signs: _____
_____	_____
4. _____	_____
_____	_____
Synopsis: _____	Baseline neurological status: _____
_____	_____
_____	_____

Last name:

Medical History:					
AIDS		Headaches		Palpitations	
Arthritis		Hearing Impairment		Periods of Unconsciousness	
Asthma		Heart Condition		Rheumatic Fever	
Bronchitis		Hemodialysis		Rheumatism	
Cancer		Hepatitis		Seizures	
Chest Pain/Pressure		High Blood Cholesterol		Shortness of Breath	
Diabetes		High Blood Pressure		Stomach, Liver or Intestinal Problems	
Dizziness		HIV Positive			
Emphysema		Hypoglycemia		Thyroid Problems	
Epilepsy		Jaundice		Tuberculosis	
Eye Problem		Kidney Disease		Tumor	
Fainting		Low Blood Pressure		Urinary Tract Infection	
Glaucoma		Mental Retardation		Smoking / packs per day: number of years:	
STD: <input type="checkbox"/> Chlamydia <input type="checkbox"/> Herpes <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis					

Immunizations (mm/yy)											
Dates											
DPT						Dates					
OPV/IPV						Hep A					
MMR						Hep B					
HIB						MEN					
HPV						PNU					
Influenza						TB status					
Rotavirus						Varicella					
Other						Other					
Other						Other					

Antibiotic prophylaxis:

Indication:

Medication and dose:

General Management Data:	
Allergies: Medications/Foods to be avoided	and why:
1.	
2.	
3.	
Procedures to be avoided	and why:
1.	
2.	
3.	
Best interventions to be used	
1.	
2.	
3.	

Last name:

Nutritional Accommodations:			
Dates		Dates	

Medications/Appliances:		
Medications:	Use of Medication:	Prostheses/Appliances/Assistive Technology Devices:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Behaviors and Communication:

