PERSONAL HEALTH

RECORD

FOR

____

REMEMBER TO TAKE

YOUR

PERSONAL HEALTH RECORD

WITH YOU

TO ALL DOCTOR VISITS.

Reston Hospital Center

HCA Virginia Health System

An HCA affiliate

About This Tool

Navigating the health care system can sometimes be confusing. This tool, reproduced by Fairfax County's Long Term Care Coordinating Council (LTCCC), was adapted from Eric Coleman's Care Transitions Program Personal Health Record that was funded by the John A. Hartford Foundation and the Robert Wood Johnson Foundation and further developed collectively by the Northwest Denver Connected For Health community and the Colorado Foundation for Medical Care (CFMC).

This tool will help you organize all the information you need to feel confident and make the process easier. A personal health record (PHR) is a collection of information about your health, including contact information for your doctors, scheduled appointments, the current medications you are taking, health conditions, allergies and plans for follow-up care.

Although not required, if your printer permits double-sided (duplex) printing either automatically or manually, you might consider printing this tool on both sides of the paper.

About the LTCCC

The Fairfax County Board of Supervisors chartered the LTCCC in 2002 to identify needs and create solutions for long term care services and programs that **enhance the lives of older adults and people with disabilities.**

The LTCCC includes **residents, advocates, non-profit organizations, educational institutions, businesses, local governments and faith communities.**

More information about the LTCCC and printable copies of the Fairfax County PHR are available at:
http://www.fairfaxcounty.gov/hd/ltccc

Or by calling 703-324-2051, TTY 711

PERSONAL INFORMATION

Name ____

Address ____

City, State, Zip____________________________________

Home Telephone ____________________________________

Mobile/Work Telephone ______________________________

EMERGENCY CONTACT

Name ____

Relation to Patient _________________________________

Home Telephone ____________________________________

Mobile/Work Telephone ______________________________

CAREGIVER INFORMATION

Name ____

Relation to Patient _________________________________

Home Telephone ____________________________________

Mobile/Work Telephone ______________________________

PROVIDER INFORMATION

Primary Care Doctor_______________________________

Telephone____

Other Providers____________________________________

Telephone____

Other Providers____________________________________

Telephone____

Home Care Agency__________________________________

Telephone____

Pharmacy____

Telephone____

Primary Insurance Provider

Telephone____

Subscriber ID:_____________Group #:_________________

Supplemental Insurance Provider

Telephone____

Subscriber ID:_____________Group #:_________________

MY PERSONAL GOALS

What would I like to do or accomplish over the next week, month and year? List any health, activity and life goals.

What Do I Need to Do to Reach My Goals?

RED FLAGS

These are symptoms and drug reactions I need to be able to recognize and know how to handle if they occur.

MEDICAL HISTORY

Please indicate whether you currently experience or have a history of the following medical problems.

- ☐ Cancer
  Type ______________
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ Congestive Heart Failure
- ☐ Stroke
- ☐ Kidney Disease
- ☐ High Cholesterol
- ☐ Thyroid Problem
- ☐ COPD
- ☐ Bleeding Disorder
- ☐ Seizures
- ☐ Heart Attack
- ☐ Diabetes,
  Type _______________
- ☐ Glaucoma
- ☐ Dementia/ Alzheimer's
- ☐ Anxiety
  - ☐ Former
  - ☐ Current
- ☐ Depression
  - ☐ Former
  - ☐ Current
- ☐ Other ____________

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Please indicate whether you have had the following immunizations.

- ☐ Tetanus, diphtheria, pertussis (Tdap) vaccine
- ☐ Influenza (flu) vaccine
- ☐ Pneumococcal vaccine
- ☐ Shingles vaccine

RECENT HOSPITALIZATION/ SURGERY/ ER VISITS

Date admitted: ________Date discharged: _______

Hospital: ____

Reason for hospitalization: ________________________

Date admitted: ________Date discharged: _______

Hospital: ____

Reason for hospitalization: ________________________

Date admitted: ________Date discharged: _______

Hospital: ____

Reason for hospitalization: ________________________

Date admitted: ________Date discharged: _______

Hospital: ____

Reason for hospitalization: ________________________

MY QUESTIONS FOR MY DOCTOR

Remember to discuss medication questions with your doctor

MY PRIMARY HEALTH CONCERNS

To better manage my health and medications, I can...

√ Take this Personal Health Record with me wherever I go, including all doctor visits and future hospitalizations.

√ Call my doctor when I have questions about my medications, or if I would like to change how I take my medications.

√ Inform my doctors of **ALL** medications that I take, including over-the-counter drugs, vitamins, supplements and herbal formulas.

√ Update my Medication Record with any changes to my medications.

√ Know why I am taking each of my medications.

√ Know how much, time of day and length of time I am taking **or have taken** each medication.

√ Consider using a weekly or monthly medication (pill) organizer.

√ Know possible medication side effects to watch out for and what to do if I notice any.

MY DISCHARGE CHECKLIST

Before I leave each facility, the following tasks should be completed

	I have been involved in decisions about what will take place after I leave the facility.
	I understand where I am going after I leave this facility and what will happen with me once I arrive.
	I have the name and telephone number of a person I should contact if a problem arises during my transfer.
	I understand what my medications are, how to obtain them and how to take them.
	I understand the potential side effects of each medication and whom I should call if I experience any side effects.
	I understand what symptoms I need to watch for and whom I should call when I notice them.
	I understand how to keep my health problems from intensifying.
	My doctor and nurse **have** answered my most important questions prior to my leaving the care facility.
	I have scheduled any necessary follow-up appointments with my doctor.
	I have transportation to and from this appointment.

ADVANCE CARE DIRECTIVES

Advance Care Directives are written instructions for your family and medical providers about the kind of medical treatment you would want if you became unable to give instructions. An advance directive can also specify one or more persons to make medical decisions for you in the event that you are unable to do so for yourself.

Do you have an advance care directive: ☐ Yes ☐ No

☐ Living Will☐ Five Wishes ☐ CPR Directive

☐ Resuscitate ☐ Do Not Resuscitate

☐ Medical Power of Attorney: Name/Telephone:

____

Location of the document(s)

____

Provide a copy of your advance care directive to your doctor.

MEDICATIONS & SUPPLEMENTS RECORD

Include over-the-counter drugs, vitamins, herbal formulas and any medications prescribed by a specialist. Update your record every time you add or change a medication or supplement. Do **NOT** black out old medications listed below. Instead, use a single line to cross out old medications so that you and your doctor can still read your medication history. If you are taking your medications differently than prescribed, please discuss your reasons with your doctor.

Known Allergies: ______________________________

Drug Name Brand name, generic name, dose	**It looks like...** Color, shape, etc.	**How many?** # of pills	**How do I take it?** with water, food, etc.	**Start** Date	**Stop** Date	**Doctor Name**
When I wake up, I take...						

Drug Name Brand name, generic name, dose	**It looks like...** Color, shape, etc.	**How many?** # of pills	**How do I take it?** with water, food, etc.	**Start** Date	**Stop** Date	**Doctor Name**
In the afternoon, I take...						
In the evening, I take...						

Drug Name Brand name, generic name, dose	**It looks like...** Color, shape, etc.	**How many?** # of pills	**How do I take it?** with water, food, etc.	**Start** Date	**Stop** Date	**Doctor Name**
Before I go to bed, I take...						
Other medicines that I do not take every day...						

Medication & Supplement Record created by: National Transitions of Care Coalition

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For more information or to request this information in an alternate format, call the Fairfax County Health Department at 703-246-2411, TTY 711.

www.fairfaxcounty.gov/hd