Your Pennsylvania

Health Record Log & Medication Chart

is for your personal health information.

Take this with you when you visit your physician, or pharmacist, to ensure you receive the services necessary to help you stay healthy.

List medications and other health remedies you are taking

Pharmacist **Phone #**

Medication	Dose	How Often

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Medication	Dose	How Often

Doctor Visits

Date of Visit Month/Day/Year	Date of Visit Month/Day/Year	Date of Visit Month/Day/Year

Doctor Visits

Date of Visit Month/Day/Year	Date of Visit Month/Day/Year	Date of Visit Month/Day/Year

Please have your physician fill out this section.

Health Screenings	Date	Results	Date	Results
Blood Pressure Yearly (or as needed)				
Vision Glaucoma Yearly (or as needed)				
Weight Physical Exam Yearly (or as needed)				
Cholesterol Yearly (or as needed)				
Blood Sugar Yearly (or as needed)				
Dental Yearly (or as needed)				

Please have your physician fill out this section.

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Dental Yearly (or as needed)				

Please have your physician fill out this section.

Health Screenings	Date	Results	Date	Results
Hearing Yearly (or as needed)				
Fecal Occult Blood Yearly (or as needed)				
Sigmoidoscopy Every 3-5 Years (or as needed)				
Prostate PSA Yearly (or as needed)				
Mammogram Every 1-2 years (or as needed)				
Pap Smear Every 1-3 years (or as needed)				
Bone Mass (as needed)				

Please have your physician fill out this section.

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Please have your physician fill out this section.

Vaccine	Date	Place
Tetanus Diphtheria (TD) After initial series, booster every 10 years.		
Pneumonia (Pneumococcal) (At least once and then every 5 years after.)		

	Date				
Flu (Influenza) Over age 65 every year.					

Do you have	Year of Diagnosis
Diabetes: Type ☐ 1 ☐ 2	
Asthma	
Hypertension	
Depression	
Alcohol Abuse	
Urinary Incontinence	
Cancer, Type:	
Heart Disease	
Other:	
Other:	
Other:	

Surgeries	Year

Family History

Do any of your siblings, parents, or grandparents have a history of:

- ☐ Diabetes
- ☐ Depression
- ☐ Alcohol Abuse
- ☐ Cancer _____ (Type)
- ☐ Other _____
- ☐ Asthma
- ☐ Hypertension
- ☐ Heart Disease Before Age 60

Personal Habits

☐ Currently smoke

_____ Cigars
_____ Pipes
_____ Cigarettes (pack)
_____ per day, for _____ years

☐ Stopped smoking _____ (approx. year)

☐ Drink Alcohol _____ ounces per day

☐ Exercise _____ minutes, _____ days a week

Health Insurance Information

Name of Primary Health Insurance _____

_____

Insurance ID # _____

Group ID # _____

HMO: ☐ Yes ☐ No

HMO Name _____

Supplemental Health Insurance _____

_____

Insurance # _____

Medicare # _____

Other Health Insurance/Medical Assistance _____

_____

Insurance ID # _____

Group ID # _____

HMO: ☐ Yes ☐ No

HMO Name _____

Supplemental Health Insurance _____

_____

Insurance # _____

Medicare # _____

Dental Insurance _____

_____

Insurance ID # _____

Group ID # _____

Medicare # _____

Other Information # _____

Vision Insurance _____

_____

Insurance ID # _____

Group ID # _____

Other Information _____

Please list your current physicians

Name _____

Specialty _____

Phone _____

Name _____

Specialty _____

Phone _____

Name _____

Specialty _____

Phone _____

Name _____

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Phone _____

Name _____

Specialty _____

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Name _____

Specialty _____

Phone _____

Name _____

Specialty _____

Phone _____

Personal Information

Name _____

Address _____

City _____

State _____ Zip _____

Phone _____

☐ Male ☐ Female ☐ Prefer Not to Answer

Date of Birth _____

Social Security # _____

Blood Type _____

Allergies/Sensitivities _____

_____

_____

Emergency Contact Information

Name _____

Phone _____

Do you have a caregiver? _____

Name _____

Phone _____

Relationship _____

Advanced Directives

☐ Living Will ☐ Declaration of Physicians

☐ Durable Power of Attorney for Health Care

Kept at _____

_____

_____

Notes

Notes

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