

**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.



## Pharmacist

**Phone #**[illegible]

**Phone #**[illegible]

## Doctor Visits

[illegible]

## Doctor Visits

[illegible]

Please have your physician fill out this section.

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

Please have your physician fill out this section.

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<b>Blood Sugar</b> Yearly (or as needed)				
<b>Dental</b> Yearly (or as needed)				



Please have your physician fill out this section.

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

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Please have your physician fill out this section.

Vaccine	Date		Place		
<b>Tetanus Diphtheria (TD)</b>  After initial series, booster every 10 years.					
<b>Pneumonia (Pneumococcal)</b>  (At least once and then every 5 years after.)					
		Date			
<b>Flu (Influenza)</b>  Over age 65 every year.					

Do you have	Year of Diagnosis
Diabetes: Type <input type="checkbox"/> 1 <input type="checkbox"/> 2	
Asthma	
Hypertension	
Depression	
Alcohol Abuse	
Urinary Incontinence	
Cancer, Type:	
Heart Disease	
Other:	
Other:	
Other:	

[illegible]

## **Family History**

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

- |  |  |
|--|--|
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Asthma                      |
| <input type="checkbox"/> Depression    | <input type="checkbox"/> Hypertension                |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Heart Disease Before Age 60 |
| <input type="checkbox"/> Cancer _____  |  |
|  | Type _____   |
| <input type="checkbox"/> Other _____   |  |
| _____                                  |  |
| _____                                  |  |
| _____                                  |  |
| _____                                  |  |
| _____                                  |  |

## **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 \_\_\_\_\_

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**Please list your current physicians**

Name \_\_\_\_\_

Specialty \_\_\_\_\_

Phone \_\_\_\_\_

Name \_\_\_\_\_

Specialty \_\_\_\_\_

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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 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

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