

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.

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.

Health Screenings	Date	Results	Date	Results
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Cholesterol Yearly (or as needed)				
Blood Sugar Yearly (or as needed)				
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.

Health Screenings	Date	Results	Date	Results
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Please have your physician fill out this section.

Vaccine	Date		Place		
<p style="text-align: center;">Tetanus Diphtheria (TD)</p> <p style="text-align: center;">After initial series, booster every 10 years.</p>					
<p style="text-align: center;">Pneumonia (Pneumococcal)</p> <p style="text-align: center;">(At least once and then every 5 years after.)</p>					
		Date			
<p style="text-align: center;">Flu (Influenza)</p> <p style="text-align: center;">Over age 65 every year.</p>					

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:	

Surgeries	Year

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 _____

Please list your current physicians

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 _____

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