# Personal Health Record

Health Services
LOS ANGELES COUNTY

**This Personal Health Record belongs to:**

_____

**Primary physician:**

_____ (_____) - _____-_____
*primary physician's name* *phone number*

**Specialty physician(s):**

_____ (_____) - _____-_____
*physician name/specialty* *phone number*

_____ (_____) - _____-_____
*physician name/specialty* *phone number*

**Pharmacy:**

_____ (_____) - _____-_____
*pharmacy name* *phone number*

**Remember to take this Personal Health Record with you to all of your hospital and doctor visits.**

**I am receiving transitional care services from:**

_____ (_____) - _____-_____
*name of facility* *phone number*

**My coach is:**

_____
*name of transition coach*

(_____) - _____-_____ (_____) - _____-_____
*office phone number* *alternate phone number*

**I am receiving home care from:**

_____ (_____) - _____-_____
*Name of home health agency* *phone number*

**Other community services I am receiving:**

_____ (_____) - _____-_____
*name of service* *phone number*

_____ (_____) - _____-_____
*name of service* *phone number*

_____ (_____) - _____-_____
*name of service* *phone number*

## PERSONAL INFORMATION

**My home address is:**

_____
*number and street*

_____ _____
*city and state* *zip code*

**My contact telephone numbers are:**

(_____) - _____-_____ (_____) - _____-_____
*home phone number* *alternate phone number*

**Advance Directive(s)** (Check all that apply.)

☐ Living Trust ☐ DPAHC ☐ POLST ☐ DNR

_____ (_____) - _____-_____
*Name of Health Care Proxy* *Phone Number*

**Location of my Advance Directive(s)**

_____

**Organ Donor** ☐ Yes ☐ No

## CAREGIVER INFORMATION

**My primary caregiver is:**

(_____) - _____-_____ (_____) - _____-_____
*home phone number* *alternate phone number*

_____
*relationship*

## RECORD OF HOSPITALIZATIONS:

Admitted ___/___/_____ Discharged___/___/_____

Name of Hospital: _____

Reason for Hospitalization:

_____

Admitted ___/___/_____ Discharged___/___/_____

Name of Hospital: _____

Reason for Hospitalization:

_____

Admitted ___/___/_____ Discharged___/___/_____

Name of Hospital: _____

Reason for Hospitalization:

_____

**MY PERSONAL HEALTH GOAL(S):**

_____

_____

_____

_____

_____

_____

**MY HEALTH CONDITIONS:**

**1.** _____

Red Flag:_____

Action Step:_____

**2.** _____

Red Flag:_____

Action Step:_____

**3.** _____

Red Flag:_____

Action Step:_____

**FOLLOW-UP PHYSICIAN APPOINTMENT(S):**

Appointment date ___/___/_____ Time: _____

Name of primary care physician: _____

Appointment date ___/___/_____ Time: _____

Name of specialty physician/clinic_____

Appointment date ___/___/_____ Time: _____

Name of specialty physician/clinic_____

**APPOINTMENT FOR BLOOD TEST(S)**

Appointment date ___/___/_____ Time: _____

Appointment date ___/___/_____ Time: _____

Appointment date ___/___/_____ Time: _____

**APPOINTMENT FOR SPECIAL STUDIE**S

Appointment date ___/___/_____ Time: _____

Type of study : _____

Appointment date ___/___/_____ Time: _____

Type of study : _____

Appointment date ___/___/_____ Time: _____

Type of study : _____

## QUESTIONS FOR MY PHYSICIAN(S)

**1.** _____

_____

_____

_____

**2.** _____

_____

_____

_____

**3.** _____

_____

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_____

**4.** _____

_____

_____

# RECORD OF MY MEDICINES

**Allergies: _____**

**Part D Plan: _____**

| MY MORNING MEDICINES | | | | |
|---|---|---|---|---|
| Name and dose of medicine | How many | Reason | New *Yes or No* | Place Pill here |
| | | | | |
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*Please include Over-the-Counter and Herb preparations*

| MY AFTERNOON MEDICINES | | | | |
|---|---|---|---|---|
| **Name and dose of medicine** | **How many** | **Reason** | **New** ***Yes or No*** | **Place Pill here** |
| | | | | |
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*Please include Over-the-Counter and Herb preparations*

| MY EVENING MEDICINES | | | | |
|---|---|---|---|---|
| **Name and dose of medicine** | **How many** | **Reason** | **New** ***Yes or No*** | **Place Pill here** |
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*Please include Over-the-Counter and Herb preparations*

| MY BEDTIME MEDICINES | | | | |
|---|---|---|---|---|
| **Name and dose of medicine** | **How many** | **Reason** | **New** ***Yes or No*** | **Place Pill here** |
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*Please include Over-the-Counter and Herb preparations*

# MY DISCHARGE PREPARATION CHECKLIST

**Before I leave the hospital, I accept the responsibility to:**

1. Be involved in decisions about what will take place after I leave the hospital.

2. Get answers to my most important questions prior to leaving the hospital.

3. Let my family or someone close to me knows that I am coming home, what I will need (medicine, supplies, and medical equipment), and what I need help with once I leave the hospital.

4. If I am going directly home, schedule a follow-up appointment with my doctor, and I have transportation to this appointment.

5. Review my discharge instructions and ask for help if I don't understand them.

This material was adapted from a tool developed by Dr. Eric Coleman, UCHSC, HCPR, with funding from the John A. Hartford Foundation and the Robert Wood Johnson Foundation

## MY DISCHARGE PREPARATION CHECKLIST

**Before I leave the hospital, I need to know:**

1. Where I am going after I leave the hospital and what will happen to me once I arrive.

2. The name and phone number of a person I should contact if a problem arises during my transfer.

3. What my medicines are, how I will obtain them today, and how to take them.

4. The potential side effects of my medicines and whom I should call if I experience them.

5. What symptoms I need to watch out for and whom to call should I notice them.

6. How to keep my health problems from becoming worse.

7. When my next medical appointment is scheduled.

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**NOTES:**