Personal Health Record of:

__________________________
(NAME)

If you have questions or concerns, contact __________________________
at (_______) _______ - ________

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REMEMBER to take this record with you to all doctor visits
**Personal Information**

**Family Caregiver Information**
Name: ________________________________
Relation to Patient: __________________
Phone #: ____________________________
Alternate Phone #: ____________________
In what ways do your caregivers help you manage your conditions?

____________________________

**Advance Directive / Living Will:**
□ NO □ YES Where can this be found?

____________________________

**Health Care Provider Information**
Primary Care Dr.: __________________________
Phone #: ________________________________
Pharmacy: _______________________________
Other Providers: __________________________

**Questions for other Providers:**

Pharmacist

Case Manager

Other (list name, specialty, organization)
Questions for my Primary Care Doctor:

My Health Conditions:

1.
   - Red Flags: 
   - Action Steps: 

2.
   - Red Flags: 
   - Action Steps: 

3.
   - Red Flags: 
   - Action Steps: 

4.
   - Red Flags: 
   - Action Steps: 

5.
   - Red Flags: 
   - Action Steps: 
Personal Goal

Notes:
Allergies

Medication Record
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<th>How Often?</th>
<th>Reason</th>
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