

# Personal Health Record

Last name:



[www.hilopaa.org/resources/phr.doc](http://www.hilopaa.org/resources/phr.doc)

Date form completed	By Whom	Revised	Initials
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Name:	Birth date:	Nickname:	<input type="checkbox"/> Adv. Directives <input type="checkbox"/> Self Guardian
Home Address:		Home/Work Phone:	
Parent/Guardian:		Emergency Contact Names & Relationship:	
Signature/Consent:			
Ht:	Wt:	Blood Type:	How I Communicate:
Primary Language:		Phone Number(s):	
<b>Physicians:</b>			
Primary care physician:		Emergency Phone:	
		Fax:	
Current Specialty physician:		Emergency Phone:	
Specialty:		Fax:	
Current Specialty physician:		Emergency Phone:	
Specialty:		Fax:	
Dentist:		Emergency Phone:	
Anticipated Primary ED:		Pharmacy:	
Anticipated Tertiary Care Center: <input type="checkbox"/> Queens <input type="checkbox"/> Kaiser <input type="checkbox"/> Tripler <input type="checkbox"/> Kapiolani <input type="checkbox"/> Straub <input type="checkbox"/> St. Francis			

<b>Current or Active Conditions:</b>	
1. _____	Baseline physical findings: _____
_____	_____
2. _____	_____
_____	_____
3. _____	Baseline vital signs: _____
_____	_____
4. _____	_____
_____	_____
Synopsis: _____	Baseline neurological status: _____
_____	_____
_____	_____

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Medical History:			
AIDS		Headaches	Palpitations
Arthritis		Hearing Impairment	Periods of Unconsciousness
Asthma		Heart Condition	Rheumatic Fever
Bronchitis		Hemodialysis	Rheumatism
Cancer		Hepatitis	Seizures
Chest Pain/Pressure		High Blood Cholesterol	Shortness of Breath
Diabetes		High Blood Pressure	Stomach, Liver or Intestinal Problems
Dizziness		HIV Positive	
Emphysema		Hypoglycemia	Thyroid Problems
Epilepsy		Jaundice	Tuberculosis
Eye Problem		Kidney Disease	Tumor
Fainting		Low Blood Pressure	Urinary Tract Infection
Glaucoma		Mental Retardation	Smoking / packs per day: number of years:
STD: <input type="checkbox"/> Chlamydia <input type="checkbox"/> Herpes <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis			

Immunizations (mm/yy)											
Dates						Dates					
DPT						Hep A					
OPV/IPV						Hep B					
MMR						MEN					
HIB						PNU					
HPV						TB status					
Influenza						Varicella					
Rotavirus						Other					
Other						Other					

Antibiotic prophylaxis: \_\_\_\_\_ Indication: \_\_\_\_\_ Medication and dose: \_\_\_\_\_

General Management Data:	
Allergies: Medications/Foods to be avoided	and why:
1.	
2.	
3.	
Procedures to be avoided	and why:
1.	
2.	
3.	
Best interventions to be used	
1.	
2.	
3.	

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**Nutritional Accommodations:**

Dates		Dates	

**Medications/Appliances:**

Medications:	Use of Medication:	Prostheses/Appliances/Assistive Technology Devices:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

**Behaviors and Communication:**


