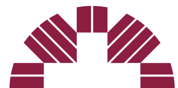
MOUNT CARMEL

My Personal Health Record



BECAUSE OF YOU

MOUNT CARMEL

This Health Record Belongs to

Name ______________________________

Address ______________________________

____

____

____

Contact Information

Home phone ______________________________

Cell phone ______________________________

Work phone ______________________________

E-mail address ______________________________

Emergency contact ______________________________

Relationship ______________________________

Phone number ______________________________

Legal Information

Advance Directive/Living Will location: ____________________

____

Summary of wishes: ____________________

____

____

____

Durable Power of Attorney for Healthcare

Responsible person ____________________

Phone number ____________________

Medication List

Please list ALL medications that you take including over-the-counter medications, herbal supplements, and vitamins. Cross off medications when they are stopped.

Medication	Dosage/ How Often Taken	Reason

Medication List

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Medication	Dosage/ How Often Taken	Reason

Vaccines

Tetanus: dates given ______________________________

____

____

Pneumonia: dates given ___________________________

____

____

Influenza (flu): dates given _______________________

____

____

Other: _______________________________________

____

____

Allergies/Adverse Reactions

Medication	What Happens

Food	What Happens

Other	What Happens

Medical Conditions

List the date that you were diagnosed with each condition.

Brain/Nerves

____

____

____

Heart/Blood Vessels

____

____

____

Lungs

____

____

____

Stomach and Bowel

Kidney and Bladder

Reproductive

Diabetes or Thyroid

Infections

Skin

Other

Diabetes or Thyroid

Surgeries

______________________________ Date__________

______________________________ Date__________

______________________________ Date__________

______________________________ Date__________

______________________________ Date__________

______________________________ Date__________

______________________________ Date__________

______________________________ Date__________

______________________________ Date__________

______________________________ Date__________

______________________________ Date__________

______________________________ Date__________

Diagnostic Tests

X-rays, Mammograms, CT Scan, MRI, Lab Reports

Name of Test	Date/Place	Result

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X-rays, Mammograms, CT Scan, MRI, Lab Reports

Name of Test	Date/Place	Result

Important Information

Doctors

Name ____

Address ____

City ____________________ State ________ Zip ________

Telephone ____________________ Fax _______________

E-Mail ____

Office Nurse's Name ______________________________

Name ____

Address ____

City ____________________ State ________ Zip ________

Telephone ____________________ Fax _______________

E-Mail ____

Office Nurse's Name ______________________________

Name ____

Address ____

City ____________________ State ________ Zip ________

Telephone ____________________ Fax _______________

E-Mail ____

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Office Nurse's Name ________________________________

Name ____

Address ____

City ______________________ State ________ Zip ________

Telephone ______________________ Fax ________________

E-Mail ____

Office Nurse's Name ________________________________

Name ____

Address ____

City ______________________ State ________ Zip ________

Telephone ______________________ Fax ________________

E-Mail ____

Office Nurse's Name ________________________________

Important Information

Pharmacy

Name ____

Address ____

City ____________________ State__________ Zip__________

Telephone ____________________ Fax__________________

E-Mail ____

Name ____

Address ____

City ____________________ State__________ Zip__________

Telephone ____________________ Fax__________________

E-Mail ____

Insurance Information

Always carry your current insurance card.

Name ____

Plan Number ______________________________________

Phone Number _____________________________________

Name ____

Plan Number ______________________________________

Phone Number _____________________________________

Notes

Notes

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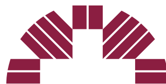

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mountcarmelhealth.com

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