

**HELP US    HELP YOU**



# Your Personal Health Record

*from* \_\_\_\_\_ *to* \_\_\_\_\_



**Illinois  
State  
Medical  
Society**

## Here's to Your Health!

The doctors of the Illinois State Medical Society want to partner with you to assure the best possible physician/patient interaction, whenever and wherever you seek your health care. Please accept this handy resource with our best wishes for your good health. Consider keeping it with you at all times, but especially when you have a doctor appointment. Your physician and his or her staff will appreciate knowing your up-to-date information.

- A. Identification **1**
- B. Emergency Contacts **1-2**
- C. Allergies/Drug Sensitivities **3**
- D. Medications **4-5**
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## A. Identification

Name (Last)			(First)	(Middle)
Primary Address				
City		State	Zip	Country
Home Phone	Work Phone		Cell Phone	
E-mail Address				
Date of Birth		Height	Weight	
Ethnicity/Race		Blood /RH Type		
Special Conditions		Allergies		
Primary Health Insurance Carrier			Policy Number	

## B. Emergency Contacts

*In Case of Emergency, Notify: **Primary Contact***

Name (Last)			(First)	(Middle)
Relationship				
Primary Address				
City		State	Zip	Country
Home Phone	Work Phone		Cell Phone	
E-mail Address				

## B. Emergency Contacts continued

*In Case of Emergency, Notify: Secondary Contact*

Name (Last) (First) (Middle)

Relationship

Primary Address

City State Zip Country

Home Phone Work Phone Cell Phone

E-mail Address

*In Case of Emergency, Notify: Medical Contacts*

Physician (Indicate Specialty)

Address Phone

Dentist Phone

Pharmacy Phone

Notes

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## C. Allergies/Drug Sensitivities

### C. Allergies/Drug Sensitivities

Allergy/Sensitivity Type (Include medications, foods, environmental, iodine, latex)	Reaction	Date Last Occurred	Treatment

## D. Medications

(Prescription/Nonprescription) Update Regularly

### D. Medications (Prescription/Nonprescription) Update Regularly

Current Drug and Strength	Dose/Frequency	Start/Stop Dates	Reason	Doctor	Comments

4

Note: Include all prescription medications, over-the-counter medications (taken on a regular basis), vitamin supplements, and herbal remedies.

## D. Medications continued

(Prescription/Nonprescription) Update Regularly

### D. Medications (Prescription/Nonprescription) Update Regularly

Current Drug and Strength	Dose/Frequency	Start/Stop Dates	Reason	Doctor	Comments

5

Note: Include all prescription medications, over-the-counter medications (taken on a regular basis), vitamin supplements, and herbal remedies.

## E. Physicians & Other Health Care Providers

1

Health Care Provider Specialty \_\_\_\_\_  Yes  No  
Primary Care Physician

Name \_\_\_\_\_

Group or Association \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

Phone \_\_\_\_\_ Emergency Phone (after hours) \_\_\_\_\_

E-mail Address \_\_\_\_\_

Fax \_\_\_\_\_ Web Address/URL \_\_\_\_\_

2

Health Care Provider Specialty \_\_\_\_\_  Yes  No  
Primary Care Physician

Name \_\_\_\_\_

Group or Association \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

Phone \_\_\_\_\_ Emergency Phone (after hours) \_\_\_\_\_

E-mail Address \_\_\_\_\_

Fax \_\_\_\_\_ Web Address/URL \_\_\_\_\_

6

## E. Physicians & Other Health Care Providers

3

Health Care Provider Specialty \_\_\_\_\_  Yes  No  
Primary Care Physician

Name \_\_\_\_\_

Group or Association \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

Phone \_\_\_\_\_ Emergency Phone (after hours) \_\_\_\_\_

E-mail Address \_\_\_\_\_

Fax \_\_\_\_\_ Web Address/URL \_\_\_\_\_

4

Health Care Provider Specialty \_\_\_\_\_  Yes  No  
Primary Care Physician

Name \_\_\_\_\_

Group or Association \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

Phone \_\_\_\_\_ Emergency Phone (after hours) \_\_\_\_\_

E-mail Address \_\_\_\_\_

Fax \_\_\_\_\_ Web Address/URL \_\_\_\_\_

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## F. Insurance Providers

### 1 Primary

Insurance Provider Type (for example: PPO, HMO)

Company Name

Address

City State Zip Country

Contact—Name Phone

Identification—Group Number Member (ID) Number

Contact Phone Emergency Phone (after hours)

E-mail Address Fax

Web Address/URL

Primary Insured Person—Name Social Security No.

Employer Name

Address

City State Zip Country

Phone

## F. Insurance Providers continued

### 2 Secondary

Insurance Provider Type (for example: PPO, HMO)

Company Name

Address

City State Zip Country

Contact—Name Phone

Identification—Group Number Member (ID) Number

Contact Phone Emergency Phone (after hours)

E-mail Address Fax

Web Address/URL

Primary Insured Person—Name Social Security No.

Employer Name

Address

City State Zip Country

Phone

## G. Medical History *(check appropriate items)*

	Date of Onset
<input type="checkbox"/> AIDS or HIV positive	
<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Asthma	
<input type="checkbox"/> Bronchitis	
<input type="checkbox"/> Cancer - <i>List Type(s):</i>	
<input type="checkbox"/> Chlamydia	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Dizziness	
<input type="checkbox"/> Emphysema	
<input type="checkbox"/> Epilepsy	
<input type="checkbox"/> Eye Problem	
<input type="checkbox"/> Fainting	
<input type="checkbox"/> Frequent or Severe Headache	
<input type="checkbox"/> Glaucoma	
<input type="checkbox"/> Gonorrhea	
<input type="checkbox"/> Hearing Impairment	
<input type="checkbox"/> Heart Condition - <i>List Type(s):</i>	
<input type="checkbox"/> Hemodialysis	
<input type="checkbox"/> Herpes	
<input type="checkbox"/> High Blood Cholesterol	
<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Hypoglycemia	
<input type="checkbox"/> Jaundice	
<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Low Blood Pressure	
<input type="checkbox"/> Mental Retardation	
<input type="checkbox"/> Periods of Unconsciousness	
<input type="checkbox"/> Rheumatic Fever	
<input type="checkbox"/> Rheumatism	
<input type="checkbox"/> Seizures	
<input type="checkbox"/> Shortness of Breath	
<input type="checkbox"/> Stomach, Liver, or Intestinal Problems	
<input type="checkbox"/> Syphilis	
<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Tumor	
<input type="checkbox"/> Thyroid Problems	
<input type="checkbox"/> Urinary Tract Infection	
<input type="checkbox"/> Other	

## H. Infectious Diseases

Disease	Age	Date	Remarks
Chicken Pox			
Hepatitis <i>List Type(s):</i>			
Measles			
Mumps			
Pertussis / Whooping Cough			
Pneumonia			
Polio			
Rubella			
Scarlet Fever			
Other			

## I. Common Adult Immunizations

Immunization for	Age	Date
Hepatitis A		
Hepatitis B		
Human papillomavirus (HPV)		
Influenza		
Measles, mumps, rubella (MMR)		
Meningococcal		
Pneumococcal		
Tetanus, diphtheria, pertussis		
Varicella		

## J. Lab or Imaging

(Examples: X-ray, MRI, Mammogram, blood work)

Date	Test Type	Requesting Doctor	Test Location	Test Results (Normal/Abnormal? Why Abnormal?)

## J. Lab or Imaging continued

(Examples: X-ray, MRI, Mammogram, blood work)

Date	Test Type	Requesting Doctor	Test Location	Test Results (Normal/Abnormal? Why Abnormal?)

## K. Family Member History

Check all items that apply to the present state of family members' health or any illnesses they have had. Enter ages of relatives. If deceased, indicate age and cause of death.

	Mother	Father	Sibling(s)	Grandparent(s)	Children	Other
Alcoholism						
Arthritis						
Asthma						
Cancer						
Diabetes						
Emphysema						
Glaucoma						
Heart Condition						
Hemodialysis						
Hepatitis						
High Blood Cholesterol						
High Blood Pressure						
Kidney Disease						
Mental Retardation						
Rheumatic Fever						
Seizures						
Smoking						
Stomach, Liver or Intestinal Problems						
Stroke						
Thyroid Disorders						
Tuberculosis						
Tumor						
Other						

## L. Medical Devices

(Examples: Pacemaker, insulin pumps, breathing devices, implants, joints, heart valves)

Device	Tracking Number
Manufacturer	Date
Hospital	
Reason	

Device	Tracking Number
Manufacturer	Date
Hospital	
Reason	

## M. Health Log

Non-infectious major illnesses/conditions. Include pregnancies and childbirth.

Date Diagnosed	Doctor	Age of Onset	Condition Status/Remarks*

\*Such as medications, special tests, x-rays, length of hospital stay, surgery, etc.

## M. Health Log continued

Non-infectious major illnesses/conditions. Include pregnancies and childbirth.

Date Diagnosed	Doctor	Age of Onset	Condition Status/Remarks*

## M. Health Log

Non-infectious major illnesses/conditions. Include pregnancies and childbirth.

\*Such as medications, special tests, x-rays, length of hospital stay, surgery, etc.

## N. Hospitalizations/Surgeries

1

Hospitalization Type (includes emergency visits)

Admission Date

Discharge Date

Doctor

Hospital

Reason

2

Hospitalization Type (includes emergency visits)

Admission Date

Discharge Date

Doctor

Hospital

Reason

3

Hospitalization Type (includes emergency visits)

Admission Date

Discharge Date

Doctor

Hospital

Reason

18

## N. Hospitalizations/Surgeries continued

4

Hospitalization Type (includes emergency visits)

Admission Date

Discharge Date

Doctor

Hospital

Reason

5

Hospitalization Type (includes emergency visits)

Admission Date

Discharge Date

Doctor

Hospital

Reason

6

Hospitalization Type (includes emergency visits)

Admission Date

Discharge Date

Doctor

Hospital

Reason

19

## O . Legal Documents/ Medical Directives

Check all that you keep on file:

- Living Will                       Durable Power of  
Attorney for Health Care
- Power of Attorney       Do Not Resuscitate Status

Document(s) Location (Physical Location, such as lock box, bank)

Location Name (for example, Bank of America)

Address

City                      State                      Zip                      Country

Legal Representative

(Name of person to whom you have assigned legal authority)

Address

City                      State                      Zip                      Country

Home Phone

Cell Phone

Pager

E-mail Address

Work E-mail Address

Work Phone

Fax

## O . Legal Documents/Medical Directives continued

Contact (Name of person who has access to the document(s))

Address

City                      State                      Zip                      Country

Contact Information

Home Phone

Cell Phone

Pager

E-mail Address

Work Phone

Work E-mail Address

Fax

Date Filed

Yes     No  
Are You An Organ Donor?

State Where Registered

Notes







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