Reminder
Take this record with you to all your doctor visits.

Name  

OVERLAKE
Hospital
Medical
Center
Medical excellence every day™
Personal Information

Name: 

Address: 

Home phone: 

Birth date: 

Insurance Company and #: 

Primary Care Physician: 

Specialty Physicians: 

Caregiver/Emergency Contact

Name: 

Home phone: 

Alternate phone: 

Relationship to patient: 
Call my doctor if I have questions about my medications or if I want to change how I take my medications.

Tell my doctor about all medications I am taking, including over-the-counter drugs, vitamins and herbal formulas.

Update my medication record with any changes to my medications.

Know why I am taking each of my medications.

Know how much, when and how long I am to take each medication.

Know possible medication side effects and what to do if I notice any changes.
Medication Record

List all medications, vitamins, dietary supplements and herbal preparations that you take. Keep this list updated and with you at all times. Bring it with you to all appointments, when you travel, visit a hospital or other care facility.

<table>
<thead>
<tr>
<th>Home Medication Name</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
<th>Purpose/Reason for Use</th>
<th>Prescriber</th>
<th>Start Date</th>
<th>Stop Date</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Easymed</td>
<td>25 MG</td>
<td>By Mouth</td>
<td>Twice Daily</td>
<td>Blood Pressure</td>
<td>Dr. Jones</td>
<td>12/1/07</td>
<td>1/2/08</td>
<td></td>
</tr>
</tbody>
</table>

Date Updated: ____________________________

<table>
<thead>
<tr>
<th>Allergy/Sensitivity to Drugs/Food/Environment</th>
<th>Describe Reaction (Symptoms, Severity)</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Vaccinations
Influenza given: ____/____/____
Pneumonia given: ____/____/____
Tetanus given: ____/____/____

Patient Name: ____________________________
Medical History

**Personal Medical History**

Check all boxes that apply to you and your health.

- [ ] Arthritis
- [ ] Asthma
- [ ] Abnormal heart rhythm
- [ ] Bleeding/clotting disorder
- [ ] Cancer (Type)
- [ ] Diabetes
- [ ] Hardening of the arteries
- [ ] Heart disease
- [ ] High blood pressure
- [ ] Hip fracture
- [ ] Lung disease
- [ ] Medical/surgical back conditions
- [ ] Pacemaker
- [ ] Pneumonia
- [ ] Stroke

Other diagnoses: ____________________________________________________________

**Family Medical History**

Check all boxes that apply to your family medical history.

- [ ] Arthritis
- [ ] Abnormal heart rhythm
- [ ] Cancer
- [ ] Diabetes
- [ ] Hardening of the arteries
- [ ] Heart disease
- [ ] High blood pressure
- [ ] Stroke

Other diagnoses: ____________________________________________________________
Hospitalization Information

Admittance date: ___/___/____
Reason for hospitalization: ____________________________

Admittance date: ___/___/____
Reason for hospitalization: ____________________________

Admittance date: ___/___/____
Reason for hospitalization: ____________________________

Admittance date: ___/___/____
Reason for hospitalization: ____________________________
Discharge Summary

Before I leave the hospital/skilled nursing facility...

☐ I have been involved in deciding what will happen after I leave the hospital/skilled nursing facility.

☐ I understand where I am going after I leave the hospital/skilled nursing facility and what will happen when I arrive at my destination.

☐ I have with me the name and phone number of a person I should contact if there is a problem during my transfer.

☐ My family or someone close to me knows that I am coming home and what I will need.

☐ I have scheduled a follow-up appointment with my doctor.

☐ I have transportation back to my scheduled appointment.

☐ My doctor and or nurse has answered all of my questions.

I understand...

☐ What my medications are, where to get them and how to take them.

☐ What possible side effects may occur from my medications and who to call if I have any side effects.

☐ Which symptoms I need to watch for and who to call if I have any symptoms.

☐ My doctor or nurses’ responses to all of my questions.

☐ How to keep my health problems from becoming worse.
My Appointment Planner
Current Medical Appointment

Appointment Date: ____________ Time: ____________ Dr. ____________

THINGS TO TELL MY DOCTOR:
Purpose of Visit: (list your concerns and symptoms, starting with the most important ones)

1. ____________________________________________ 3. ____________________________________________
2. ____________________________________________ 4. ____________________________________________

What symptoms or conditions have changed since my last visit?
______________________________________________________________

How am I currently treating my symptoms or conditions?
______________________________________________________________

What else is happening in my life? (sleep problems, alcohol use, emotional stress, moved, death of a loved one, new activities, etc.)
______________________________________________________________

MY QUESTIONS: (things to ask in priority order)

1. ____________________________________________ 3. ____________________________________________
2. ____________________________________________ 4. ____________________________________________

MY DOCTOR’S RECOMMENDATIONS: (things to understand and do)
______________________________________________________________

New/changed medications: (name and dosage—continue on the back of this sheet if necessary)
______________________________________________________________

Treatments: (e.g., appointments with other providers, exercise, heat/ice for injuries, self-care, etc.—continue on the back of this sheet if necessary)
______________________________________________________________

FOLLOW-UP/NEXT APPOINTMENT:
______________________________________________________________

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