CITY OF COLORADO SPRINGS

Reach Your Peak
Benefits and Wellness

Personal Health Record

Your best health historian is you

PERSONAL INFORMATION

Name

Address

Home Phone

Work Phone

Cell Phone

Date of Birth (month/day/year)

EMERGENCY CONTACTS

Name

Relationship

Phone

Name

Relationship

Phone

PRIMARY CARE PROVIDER

Name

Address

Phone

Fax

INSURANCE COMPANY

Name

Policy or Group #

ID or Member #

Phone

ALLERGIES *(list drugs & food)*

ORGAN DONOR?

☐ *Yes* ☐ *No*

MEDICAL POWER OF ATTORNEY

Name

Relationship

Phone

Date and Location of Document

LIVING WILL

Attorney

Phone

Date of Will

Location of Will

Phone

PREFERRED PHARMACY

Name

Address

Phone

PREFERRED HOSPITAL

Name

Address

Phone

PHYSICIAN INFORMATION

Specialty	Name	Phone	Last Seen
Primary Care			__/__/__
Allergist			__/__/__
Cardiologist			__/__/__
Dentist			__/__/__
Endocrinologist			__/__/__
Gastroenterologist			__/__/__
Neurologist			__/__/__
Gynecology			__/__/__
Infectious Disease			__/__/__
Occupational Medicine			__/__/__
Oncologist			__/__/__
Ophthalmologist			__/__/__
Orthopedist			__/__/__
Otolaryngologist			__/__/__
Physiatrist			__/__/__
Podiatrist			__/__/__
Pulmonologist			__/__/__
Rheumatologist			__/__/__
Surgeon			__/__/__
Urologist			__/__/__
Other:			__/__/__

MEDICAL CONDITIONS

CHECK ALL THAT APPLY	***Since (YEAR)***
☐ Abnormal Heart Beat	_____
☐ AIDS/HIV	_____
☐ Alzheimer's Or Dementia	_____
☐ Asthma	_____
☐ Auto-Immune Disease	_____
☐ Cancer	_____
☐ Chronic Obstructive Pulmonary Disease (COPD) or Chronic Bronchitis	_____
☐ Coronary Artery Disease (CAD) Bypass Graft? ☐ Yes ☐ No	_____
☐ Depression	_____
☐ Diabetes - Insulin Dependent? ☐ Yes ☐ No	_____
☐ Frequent Chronic Pain (Circle All That Apply) Back Neck Knee Other _____	_____
☐ GERD (Gastro-Esophageal Reflux Disease)	_____
☐ Gastrointestinal Problems (Inflammatory Bowel Disease, Crohn's, Ulcers)	_____
☐ Heart Attack	_____
☐ High Blood Pressure	_____
☐ High Cholesterol	_____
☐ Hypothyroidism	_____
☐ Kidney And/or Prostate Problems	_____
☐ Obesity	_____
☐ Osteoarthritis	_____
☐ Pacemaker	_____
☐ Seizure Disorder	_____
☐ Stroke	_____
☐ Transient Ischemic Attacks	_____
☐ Other (Please List) _____	_____
_____	_____

HOSPITALIZATIONS,
Surgeries and ER Visits

Date Admitted	Date Discharged	Hospital & Location	Reason
__/__/__	__/__/__		
__/__/__	__/__/__		
__/__/__	__/__/__		
__/__/__	__/__/__		
__/__/__	__/__/__		
__/__/__	__/__/__		
__/__/__	__/__/__		
__/__/__	__/__/__		
__/__/__	__/__/__		
__/__/__	__/__/__		
__/__/__	__/__/__		
__/__/__	__/__/__		
__/__/__	__/__/__		

URGENT CARE & **WALK-IN** CLINIC VISITS

Date of Visit	Facility & Location	Reason For Visit
__/__/__	__/__/__	
__/__/__	__/__/__	
__/__/__	__/__/__	
__/__/__	__/__/__	
__/__/__	__/__/__	
__/__/__	__/__/__	
__/__/__	__/__/__	
__/__/__	__/__/__	

OTHER HEALTH ACTIVITIES

- ☐ Health education class for: _____
- ☐ Dietician for: _____
- ☐ Physical therapy for: _____
- ☐ Counseling for: _____
- ☐ Pain Management for: _____
- ☐ Occupational therapy for: _____
- ☐ Acupuncture for: _____
- ☐ Chiropractor for: _____
- ☐ Massage therapy for: _____

CURRENT MEDICATION & SUPPLEMENT RECORD

Medication/ Supplement	Dose	How Many	How I take It	When I take It	Reason I take It	Prescribed By	Start Date
Example: Lisinopril	***10 mg***	***1***	***By mouth with breakfast***	***☐AM ☐Noon ☐Daily ☐PM ☐Bedtime ☐Other***	***High Blood Pressure***	***Dr. Smith***	***11/2011***

PREVENTIVE SCREENINGS

FEMALE	**Date of Last**	**Physician/Facility**	**Results**
Breast Exam	_____	_____	_____
Mammogram	_____	_____	_____
Pelvic/Cervical	_____	_____	_____
Pap Smear	_____	_____	_____
Bone Density	_____	_____	_____
Colonoscopy	_____	_____	_____
Dental Exam	_____	_____	_____
Eye Exam	_____	_____	_____
Hearing Exam	_____	_____	_____
Other: _____	_____	_____	_____
Other: _____	_____	_____	_____

MALE	**Date of Last**	**Physician/Facility**	**Results**
Testicular Exam	_____	_____	_____
Digital Rectal Exam (DRE)	_____	_____	_____
Prostate Exam	_____	_____	_____
Colonoscopy	_____	_____	_____
Dental Exam	_____	_____	_____
Eye Exam	_____	_____	_____
Hearing Exam	_____	_____	_____
Other: _____	_____	_____	_____
Other: _____	_____	_____	_____

MY CURRENT…

Height _____ Weight _____ Blood Pressure ____/____ Pulse _____

Waist Circumference _____ Body Mass Index (BMI) _____

Other: _____

_____

_____

OTHER TESTS & LAB WORK

Date	Test	Physician/Lab	Results

PERSONAL HEALTH GOALS

Answers to the following questions will help you establish what's most important to you on your healthcare path.

What is one heath-related issue that is important to me and I would like to improve upon? _____

_____

What specifically would I like to do to address this issue? _____

_____

_____

_____

Is this something I can realistically accomplish? Can I think of any barriers to being successful at accomplishing this? _____

_____

_____

If this is not realistic, how can it be broken down into smaller parts so I can start with just one small piece? _____

_____

_____

_____

How much time would I like to spend each time I do this? _____

_____

How often would I like to do this? _____

What will encourage me to stay on track with this goal? _____

_____

_____

_____

What will tell me I have succeeded at this goal? _____

_____

_____

WHEN YOUR DOCTOR'S OFFICE IS CLOSED & YOU NEED **HELP**

Even if your doctor's office is closed, there is always a physician who is on call **to answer your questions and point you in the right direction.**

You can also call your primary care provider when you are unsure of the severity of your condition. Again, even in if the office is closed you will be told how to contact the on-call doctor directly.

Use the examples in the following chart to help you determine when to call your doctor's office, go to the nearest emergency room or call 911.

Call your primary care provider if you have…	**Call 911 or go directly to the emergency room if you have…**
Colds, Cough, Or Sore Throat	Head injuries
Diarrhea or upset stomach	Life or limb threatening conditions
Earaches	Loss of consciousness
Eye, sinus, or urinary tract infections	Major burns
Fever or flu symptoms	Poisoning
Minor burns or cuts	Severe bleeding
Skin rashes	Sever chest/abdominal pain
Sprains	Sudden speech loss or arm/leg numbness

NOTES/QUESTIONS & ANSWERS

NOTES/QUESTIONS & ANSWERS