Personal Health Record

Name: _____

If you have questions or concerns, contact _____

at (_____) _____ – _____

Don't forget to take this record with you to all of your doctor visits.

Personal Information

Name: _____

Date of birth: _____ Health Net ID #: _____

Address: _____

Phone #: _____

Family and/or caregiver information

Name: _____

How this person is related to patient: _____

Phone #: _____

Other phone # (e.g. work): _____

In what ways do your family and/or caregiver(s) help you manage your conditions?

_____

_____

Health care provider information

Primary care physician[1]: _____

Phone #: _____

Pharmacy: _____

Home health: _____

Infusion: _____

Durable Medical Equipment: _____

Other providers: _____

_____

Advanced Healthcare Directive/Power of Attorney (POA)

These are papers that tell your family, caregiver, and doctor what your wishes are when you can't make choices about your health care.

Have you put together your advance directive?

☐ Yes ☐ No

Where can this be found? _____

[1]This is the main doctor you see for all basic primary care services.

List recent hospital and nursing home stays:

Have you recently been to a hospital, an emergency room, or a nursing home (such as a long-term care or skilled nursing facility)? Note them here.

Hospital/Nursing Home name: _____

Date admitted: _____

Date discharged: _____

Reason: _____

_____

Hospital/Nursing Home name: _____

Date admitted: _____

Date discharged: _____

Reason: _____

_____

Hospital/Nursing Home name: _____

Date admitted: _____

Date discharged: _____

Reason: _____

_____

Hospital/Nursing Home name: _____

Date admitted: _____

Date discharged: _____

Reason: _____

_____

My Health Conditions

Red Flags (signs and symptoms to look out for)

Allergies

Questions for my Doctor

Questions for Other Health Care Providers

Specialist (Such as a cardiologist, dermatologist, nephrologist, etc.)

Pharmacist

Case Manager

Behavioral Health Provider

Home Health Provider

Medication and Supplement Record

List your medicines here and discuss with your doctor during each visit. Include over-the-counter medications for pain, allergy medicines, antacids, and sleeping pills you use on a routine basis. Make sure all your doctors know about any medication changes. This is all the more important after a hospital stay. Use a pencil to make it easy to update this list.

Name	Doctor name and phone number	Dose	How often	Reason	New
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐

Appointment Schedule

Provider: _____

Phone Number: _____

Provider: _____

Phone Number: _____

Provider: _____

Phone Number: _____

Provider: _____

Phone Number: _____

Provider: _____

Phone Number: _____

Doctor	Date	Time

My Self-Care Diary

Write down your health goals, and how you are tracking your progress. Share with your doctor at your next visit.

1 Personal Health Goal #1

How I'm Measuring My Progress:

2 Personal Health Goal #2

How I'm Measuring My Progress:

3 Personal Health Goal #3

How I'm Measuring My Progress:

Notes:

Health Net Member Services

We are here to help you and answer questions about your benefits.

800-675-6110 (TTY:711)

24 hours a day 7 days a week

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