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| Personal Health Record |

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| Date form  completed | By Whom | Revised | Initials |

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| **Name:** | **Birth date:** | **Nickname:** | **Adv. Directives** **Self Guardian** |
| **Home Address:** | **Home/Work Phone:** | | |
| **Parent/Guardian:** | **Emergency Contact Names & Relationship:** | | |
| **Signature/Consent:** |  | | |
| **Ht:**       **Wt:**       **Blood Type:** | **How I Communicate:** | | |
| **Primary Language:** | **Phone Number(s):** | | |
| **Physicians:** | | | |
| **Primary care physician:** | **Emergency Phone:** | | |
|  | **Fax:** | | |
| **Current Specialty physician:** | **Emergency Phone:** | | |
| **Specialty:** | **Fax:** | | |
| **Current Specialty physician:** | **Emergency Phone:** | | |
| **Specialty:** | **Fax:** | | |
| **Dentist:** | **Emergency Phone:** | | |
| **Anticipated Primary ED:** | **Pharmacy:** | | |
| **Anticipated Tertiary Care Center:**  **Queens**  **Kaiser**  **Tripler**  **Kapiolani**  **Straub**  **Queens West** | | | |

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| **Current or Active Conditions:** | | |
| **1.** |  | **Baseline physical findings:** |
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| **2.** |  |  |
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| **3.** |  | **Baseline vital signs:** |
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| **4.** |  |  |
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| **Synopsis:** |  |  |
|  |  | **Baseline neurological status:** |
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| **Medical History:** | | | | | |
| AIDS |  | Headaches |  | Palpitations |  |
| Arthritis |  | Hearing Impairment |  | Periods of Unconsciousness |  |
| Asthma |  | Heart Condition |  | Rheumatic Fever |  |
| Bronchitis |  | Hemodialysis |  | Rheumatism |  |
| Cancer |  | Hepatitis |  | Seizures |  |
| Chest Pain/Pressure |  | High Blood Cholesterol |  | Shortness of Breath |  |
| Diabetes |  | High Blood Pressure |  | Stomach, Liver or Intestinal Problems |  |
| Dizziness |  | HIV Positive |  |
| Emphysema |  | Hypoglycemia |  | Thyroid Problems |  |
| Epilepsy |  | Jaundice |  | Tuberculosis |  |
| Eye Problem |  | Kidney Disease |  | Tumor |  |
| Fainting |  | Low Blood Pressure |  | Urinary Tract Infection |  |
| Glaucoma |  | Mental Retardation |  | Smoking / packs per day: number of years: |  |
| STD: Chlamydia  Herpes  Gonorrhea  Syphilis | | | |  |

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| **Immunizations** (mm/yy) | | | | | | | | | | | | |
| **Dates** |  |  |  |  |  |  | **Dates** |  |  |  |  |  |
| DPT |  |  |  |  |  |  | Hep A |  |  |  |  |  |
| OPV/IPV |  |  |  |  |  |  | Hep B |  |  |  |  |  |
| MMR |  |  |  |  |  |  | MEN |  |  |  |  |  |
| HIB |  |  |  |  |  |  | PNU |  |  |  |  |  |
| HPV |  |  |  |  |  |  | TB status |  |  |  |  |  |
| Influenza |  |  |  |  |  |  | Varicella |  |  |  |  |  |
| Rotavirus |  |  |  |  |  |  | Other |  |  |  |  |  |
| COVID |  |  |  |  |  |  | Other |  |  |  |  |  |

Antibiotic prophylaxis:       Indication:       Medication and dose:

           

| **General Management Data:** | |
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| Allergies: Medications/Foods to be avoided | **and why:** |
| **1.** | |
| **2.** | |
| **3.** | |
| Procedures to be avoided | **and why:** |
| **1.** | |
| **2.** | |
| **3.** | |
| Best interventions to be used |  |
| **1.** | |
| **2.** | |
| **3.** | |

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| **Nutritional Accommodations:** | | | |
| **Dates** |  | **Dates** |  |
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| **Medications/Appliances:** | | |
| **Medications:** | **Use of Medication:** | **Prostheses/Appliances/AssistiveTechnology Devices:** |
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| **Behaviors and Communication:** |
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| **Health Log:** (Non-infectious major illnesses, special tests, x-rays, hospitalizations, surgeries, etc.) | | | |
| **Dates** |  | **Dates** |  |
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| **Special Health Care Needs with Specific Suggested Management** |
| **Problem** **Treatment Considerations** |
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| See Emergency Action Plan |

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| **Comments on family or other specific medical issues:** |
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| **Physician/Provider Signature:**  **Print Name:** |

Hilopa‘a Project - Grant #D70MC04468 from the Health Resources and Services Administration Maternal and Child Health Bureau

Family Voices of Hawai‘i, State of Hawai‘i 🙫 Department of Health Children with Special Health Needs Branch

American Academy of Pediatrics—Hawai‘i Chapter 🙫 University of Hawai‘i JABSOM Department of Pediatrics—Community Pediatrics Institute

Rev. Hilopaʻa Family to Family, Inc. 1/31/2022