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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:**       |
|        |  |       |
| **2.**       |  |       |
|        |  |       |
| **3.**  |  | **Baseline vital signs:**       |
|        |  |       |
| **4.**       |  |       |
|        |  |       |
| **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:** |
| 1.
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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:**  |
|  |
| **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