PULSE

MY PERSONAL MEDICAL DIARY

Print and make copies. Use as many as needed

www.pulsecenterforpatientsafety.org

NAME ____ **DATE OF BIRTH**_____/_______/______

I HAVE___ DO NOT HAVE___ A HEALTHCARE PROXY (NAME) _________________________ **#**____________________

I HAVE___ DO NOT HAVE___ AN ADVOCATE / CAREGIVER / PATIENT ASSISTANT _______________________________

Contact #___________________________ **(THIS FORM SHOULD NOT REPLACE AN OFFICIAL HEALTHCARE PROXY FORM)**

EMERGENCY CONTACT NAME:____________________________________ PHONE #:__________________________

RELATIONSHIP: ______________________________________ SAME AS HC PROXY___ ADVOCATE___ NEITHER___

I HAVE THE FOLLOWING ALLERGIES:____

MY PRIMARY INSURANCE COMPANY:__________________________________ **NO.**____________________________

PHONE:_______________________________ **ADDRESS:**____

MY SECONDARY INSURANCE COMPANY:________________________________**NO:**____________________________

PHONE:_______________________________ **ADDRESS:**____

I USE THE FOLLOWING HEALTHCARE PROVIDERS

____________________________ NAME	____________________________ NAME	____________________________ NAME
____________________________ PHONE	____________________________ PHONE	____________________________ PHONE
____________________________ SPECIALTY	____________________________ SPECIALTY	____________________________ SPECIALTY
____________________________ ____________________________ ADDRESS	____________________________ ____________________________ ADDRESS	____________________________ ____________________________ ADDRESS
Date Started ___________	Date Started ___________	Date Started ___________

I TAKE THE FOLLOWING MEDICATIONS

MEDICATION NAME	DOSAGE & FREQUENCY	DATE STARTED	DATE STOPPED	PRESCRIBED BY	SPECIAL INSTRUCTIONS	REASON FOR TAKING

PHARMACY:_________________ADDRESS:___________________________CITY___________STATE____ ZIP_________

PHONE #: _______________________________ FAX #: ____

I TAKE THE FOLLOWING VITAMINS AND HERBS / OTC (OVER THE COUNTER) ALLERGY, PAIN MEDICATIONS

NAME	DOSAGE & FREQENCY	DATE STARTED	DATE STOPPED	PRESCRIBED BY	SPECIAL INSTRUCTIONS	REASON FOR TAKING

I HAVE THE FOLLOWING CONDITIONS (SUCH AS ASTHMA, HIGH BLOOD PRESSURE, DIABETES)

CONDITION:_____________________________ SPECIAL INSTRUCTION:_____________________________________

CONDITION:_____________________________ SPECIAL INSTRUCTION:_____________________________________

CONDITION:_____________________________ SPECIAL INSTRUCTION:_____________________________________

CONDITION:_____________________________ SPECIAL INSTRUCTION:_____________________________________

CONDITION:_____________________________ SPECIAL INSTRUCTION:_____________________________________

I HAVE HAD THE FOLLOWING PROCEDURES / TESTS / SURGERIES

DATE	BP/HEART	HEIGHT/ WEIGHT	NAME OF PROCEDURE/ TEST OR SURGERY	REASON	PERFORMED BY:	COMMENTS