**Patient Health Record**

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| Name: | Pharmacy: |
| Birthdate: | Cross Streets: |
| Best Phone #: | Phone #: |
| Email: |  |
| Emergency Contact: |  |
| Phone #: | Check if yes: |
| Primary Doctor: |  ☐ Advanced Directive ☐ Living Will |
| Phone # |  ☐ Do Not Resuscitate ☐ POLST |

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| Blood Type |
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| Chronic Conditions |  |
| Diagnosis | Treatment |
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| Tests and Blood Work |  |
| Test or Lab | Date | Any Abnormal Results |
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| Medications |  |  |
| Year Started | Dose and Frequency | What is it for? |
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| Surgeries |  |  |
| Surgical Procedure | Year | Doctor |
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| Lifestyle Choices |  |
| Activity | Frequency |
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| Family History |  |  |
| Diagnosis | Family Member | Age Diagnosed |
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| Hospitalizations and Major Illnesses |
| Diagnosis | Date | Treatment |
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| Psychiatric Illness |
| Diagnosis | Treatment and Hospitalizations |
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| Other Doctors, Dentist, Therapist, Social Worker, or Other Important Contacts |
| **Provider name** | Specialty | Last Date Seen | Phone # | Other Information |
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| Other Important Information: |