Personal Health Record

(Photocopy this page and give to a friend in case of emergency.)

Name _____	**Date of birth** _____
Home address _____	**Email address** _____
_____	**Home phone number** _____
_____	**Work phone number** _____
_____	**Cell phone number** _____

Health card number _____

Private health insurance information: _____

Age _____ **Weight** _____ **Height** _____ **Blood type** _____

Date of HIV diagnosis _____	**Allergies and drug sensitivities** _____
Other medical conditions _____	_____
_____	_____
_____	_____

Family history (for example, has a family member ever had diabetes, heart disease, cancer, etc?)

Condition	**Family member (relation)**	**Condition**	**Family member (relation)**
_____		_____	
_____		_____	
_____		_____	

Healthcare providers

Specialty	**Name**	**Contact information**
Family doctor	_____	
_____		
HIV specialist	_____	
_____		
Pharmacy	_____	
_____		

In case of emergency, contact:

Name _____ **Relationship** _____ **Phone** _____

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History of anti-HIV drugs (keep this list current)

Anti-HIV drug	Dosing schedule	Special instructions	Date started	Date stopped	Reason for stopping

History of other drugs and/or therapies (keep this list current)

Name of drug or therapy	Dose (if applicable)	Special instructions	Date started	Date stopped	Reason for stopping

History of significant medical events, such as hospitalization, serious illness, surgery (keep this list current)

Date	Description of event	Notes

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Monitoring tests (fill in this chart with the results of each viral load test, CD4 test and any other tests you want to monitor, such as cholesterol or triglyceride levels)

Date of test											
Viral load											
CD4 cell count											

Record of symptoms and side effects

Describe symptom/side effect	When did it occur and how long did it last?	How was it treated?	Notes

Notes for visit to doctor

(Photocopy this page and use for each visit)

Changes in my health since the last visit (for example, new symptoms, illnesses, etc.)

Difficulties or challenges with my treatment and/or care

Questions for my doctor

Things I need from my doctor (for example, prescription refill, referral)

Action plan