

Name: _____ Date of Birth: _____

My Health Record

- Always keep this form with you – preferably in a wallet or purse.
- Write down all changes to your health that may occur. If you stop taking a medicine, cross it off the list. If you add another medicine, write it on the list.

In Case of Emergency

Doctor(s), and other important phone numbers:

Emergency contact(s):

Allergies (such as medicines, latex, IV dye and food; describe reaction):

Immunization Record (Record the date / year of the most recent vaccinations)

Flu vaccine(s):	Tetanus:
Pneumonia vaccine:	Hepatitis vaccine:
COVID-19:	Other:

Medical Conditions (Place a check in the box next to all that apply to your health history.)

- | | | | | |
|--|--|---|---|---------------------------------------|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Liver problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Dementia | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pneumonia | _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Psychiatric problems | |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Breast lump | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Thyroid problems | |

Surgeries (List all and year)

Signs and Symptoms of Heart Attack

- Uncomfortable pressure, fullness, squeezing or pain in the center of the chest that lasts more than a few minutes, or goes away and comes back
- Pain that spreads to the shoulders, neck, jaw or arms
- Chest discomfort, light-headedness, fainting, sweating, nausea or shortness of breath

- Additional warning signs for women:**
- Dizziness
 - Unexplained weakness or fatigue
 - Discomfort or pain between the shoulder blades
 - Sense of impending doom

Signs and Symptoms of Stroke

- Sudden numbness or weakness of the face, arm or leg, especially on one side of the body
- Sudden confusion, trouble speaking or understanding
- Sudden trouble walking, dizziness, or loss of balance or coordination
- Sudden severe headache with no known cause
- Sudden trouble seeing in one or both eyes

If you suspect you are having a heart attack or stroke, call 911 immediately. DO NOT drive yourself.

Helping you Mind Your HealthSM



Medical Group

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING.

- **Prescriptions** (examples - pills, inhalers, creams, shots)
- **Over-the-Counter Medications** (examples - aspirin, antacids)
- **Herbals** (examples - vitamins, ginseng, ginkgo)
- **Taken-as-Needed Medications** (examples - nitroglycerin, inhalers)

Date Started	Medication Name	Dose	Directions How do you take it? When? How often?	Date Stopped	Notes - Reason for taking?

To find a BJC Medical Group Physician or schedule an appointment, call 855.204.2921 or visit bjcmedicalgroup.org.