

Medical History:

- Heart Disease
- Stroke
- Diabetes
- Neurological Disorders
- Stomach/ Intestinal Problems
- Arthritis
- Asthma/ COPD
- Skin Disorder
- Depression/ Anxiety
- Memory Problems
- Impaired Hearing
- Impaired Vision
- Other _____

Advance Directive Status:

- I do not have advance directive for health care
- I have an advance directive for health care

The person who has a copy of my directive is:

Name _____

Phone _____

Allergies:

Medications:

Always carry with you a current list of your medications, the dosage and how frequently you take the medication.

Partners in Sickness Prevention:

Atlanta Regional Commission/Area Agency on Aging
 Piedmont Healthcare
 Emory Division of Geriatric Medicine

A Personal Prevention Record

If found return to

Name _____

Address _____

Phone _____

Email _____

Emergency Contact: _____

It is important that you share a copy of this record with all of your health providers each time it is updated

Healthcare providers: _____

Personal Prevention Record

(discuss what your personal target should be with your health care provider):

Blood Pressure Target: < ____ / ____

	DATE	RESULTS	DATE	RESULTS	DATE	RESULTS	DATE	RESULTS
	Follow up needed <input type="radio"/>	/	Follow up needed <input type="radio"/>	/	Follow up needed <input type="radio"/>	/	Follow up needed <input type="radio"/>	/
Cholesterol Target LDL ("bad"): < _____	Follow up needed <input type="radio"/>		Follow up needed <input type="radio"/>		Follow up needed <input type="radio"/>		Follow up needed <input type="radio"/>	
Weight Target weight: < _____	Follow up needed <input type="radio"/>		Follow up needed <input type="radio"/>		Follow up needed <input type="radio"/>		Follow up needed <input type="radio"/>	
Stool cards or Colonoscopy to detect Colon Cancer	Follow up needed <input type="radio"/>		Follow up needed <input type="radio"/>		Follow up needed <input type="radio"/>		Follow up needed <input type="radio"/>	
Pap Smear to detect Cervical Cancer (optional if post menopause and multiple normal past pap smears*)	Follow up needed <input type="radio"/>		Follow up needed <input type="radio"/>		Follow up needed <input type="radio"/>		Follow up needed <input type="radio"/>	
Mammogram to detect Breast Cancer (optional in older women with significant comorbid disease*)	Follow up needed <input type="radio"/>		Follow up needed <input type="radio"/>		Follow up needed <input type="radio"/>		Follow up needed <input type="radio"/>	

Influenza Vaccine

Pneumonia Vaccine

Tetanus (Td) Vaccine

Varicella Vaccine

*should discuss with your doctor.

DATE	DATE	DATE	DATE	Other vaccines your Doctor recommends: Vaccine _____ How often _____ Date _____ Vaccine _____ How often _____ Date _____ Vaccine _____ How often _____ Date _____ Vaccine _____ How often _____ Date _____