



Senator

XXXXX XXXXXXXX

xxth District

District Offices

Toll-Free Numbers for Information

APPRISE.....	1-800-783-7067
PACE/PACENET	1-800-225-7223
Property Tax/Rent Rebate	1-888-222-9190

Your Passport to Better Health



**SENIOR
HEALTH RECORD**



PRINT YOUR NAME HERE

**Your Senior Health Record
is for your personal
health information.**

**Take this record with you when
you visit your physician or
pharmacist to ensure you get the
services you need to help you
stay healthy.**

Use a pencil.

Diabetes Office Flow Sheet (to be completed by the physician)

	Date of Visit Mth/Day/Year	Date of Visit Mth/Day/Year	Date of Visit Mth/Day/Year	Date of Visit Mth/Day/Year
9. Has a glycosylated hemoglobin (HbA1c) been done in the last 4 months?				
10. Has a urinalysis been done in the last 6 months to check color, ph, sp. gravity, RBC, WBC, protein, and microalbuminuria?				
11. Has a chemistry panel been done in the past year including electrolytes, glucose, lipids, BUN, creatinine?				
12. Has a vision exam been done in the past year by an ophthalmologist?				
13. Are immunizations up-to-date including flu and pneumonia?				
14. Has an EKG and cardiac evaluation been done in the past year?				
15. Is the patient undergoing dialysis?				
16. Involved in alternative medicine (such as acupuncture, therapeutic massage, etc.)?				

Diabetes Office Flow Sheet *(to be completed by the physician)*

	Date of Visit Mth/Day/Year	Date of Visit Mth/Day/Year	Date of Visit Mth/Day/Year	Date of Visit Mth/Day/Year
1. Checked vital signs including temperature, pulse, respiration, blood pressure and weight?				
2. Discussed diabetic symptoms? (blurred vision, numbness/tingling in the hands and feet, dizziness, etc., frequent urination, hypoglycemic systems, skin ulcers, incontinence, sexual dysfunction).				
3. Foot exam performed (socks off every visit)? Does patient do daily checks?				
4. Discussed medications including non-prescription drugs and herbal remedies? (name, dosage, timings).				
5. Discussed dietary regimen compliance?				
6. Discussed social habits? (smoking, alcohol and drug use, exercise).				
7. Has glucose been checked today?				
8. Discussed blood glucose monitoring? (Fasting versus post prandial, calibration).				

Name: _____

Address: _____

City: _____

State/Zip: _____

Phone: _____

Date of Birth: _____

Male Female Blood Type: _____

Social Security: _____

Allergies/Sensitivities:

Pharmacist

Phone

List medications and other health remedies you are taking.
Use pencil and erase those you are not taking.

Medication	Dose	How Often

HEALTH INSURANCE INFORMATION

Health Insurance Carrier: _____

Insurance: _____

HMO: Yes No

HMO Name: _____

Supplemental Health Insurance: _____

Insurance: _____

Medicare: _____

FAMILY HISTORY

Do any of your siblings, parents, grandparents have a history of (check if yes):

- Diabetes
- Asthma
- Alcohol abuse
- Heart disease before age 60
- Cancer (type) _____
- Other _____
- Depression
- Hypertension

PERSONAL HABITS

- Currently Smoke
- Cigarettes (pack) _____ per day, for _____ years.
- Stopped Smoking (approximate year) _____
- Drink Alcohol (ounces per day) _____
- Exercise _____ minutes, _____ days a week.
- Cigars
- Pipe

Date	Results	Date	Results	Date	Results

Please have your physician fill out this section:

Health Screenings	Date	Results	Date	Results
Hearing Yearly (or as needed)				
Fecal Occult Blood Yearly (or as needed)				
Sigmoidoscopy Every 3-5 years (or as needed)				
Prostate PSA Yearly (or as needed)				
Mammogram Every 1-2 years (or as needed)				
Pap Smear Every 1-3 years (or as needed)				
Bone Mass As needed				

PLEASE LIST YOUR CURRENT PHYSICIANS

Name	Phone
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have:	When Diagnosed
<input type="checkbox"/> Diabetes, type <input type="checkbox"/> A <input type="checkbox"/> B (see page 16)	
<input type="checkbox"/> Asthma	
<input type="checkbox"/> Hypertension	
<input type="checkbox"/> Depression	
<input type="checkbox"/> Alcohol Abuse	
<input type="checkbox"/> Urinary Incontinence	
<input type="checkbox"/> Cancer, type:	
<input type="checkbox"/> Heart Disease	
<input type="checkbox"/> Other	
<input type="checkbox"/> Other	

Date	Results	Date	Results	Date	Results

Please have your physician fill out this section:

Vaccine	Date	Place				
Tetanus Diphtheria (Td) After initial series, booster every 10 years						
Pneumonia (Pneumococcal) At least once						
		Date				
Flu (Influenza) Over age 65 every year						