If you have questions or concerns, contact _____________________________
at ( ______ ) ______ - _________

REMEMBER to take this record with you to all doctor visits
Personal Information

Family Caregiver Information
Name: ____________________________
Relation to Patient: ________________
Phone #: __________________________
Alternate Phone #: ________________
In what ways do your caregivers help you manage your conditions?
________________________________

Advance Directive / Living Will:
□ NO  □ YES  Where can this be found?
________________________________

Health Care Provider Information
Primary Care Dr.: ________________
Phone #: _________________________
Pharmacy: _________________________
Other Providers: _________________

Questions for other Providers:
Pharmacist

Case Manager

Other (list name, specialty, organization)
Questions for my Primary Care Doctor:

My Health Conditions:

1. __________________________
   
   ➡ Red Flags: __________________________
   🔻 Action Steps: __________________________

2. __________________________
   
   ➡ Red Flags: __________________________
   🔻 Action Steps: __________________________

3. __________________________
   
   ➡ Red Flags: __________________________
   🔻 Action Steps: __________________________

4. __________________________
   
   ➡ Red Flags: __________________________
   🔻 Action Steps: __________________________

5. __________________________
   
   ➡ Red Flags: __________________________
   🔻 Action Steps: __________________________
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