e-Telmed

Personal Health Record (PHR)

GENERAL

First Name

Last Name

SSN

D.O.B (DD-MM-YYYY)

Gender *

Marital Status *

Height(Inches)

Weight(Lbs)

Address

City

State

Zip code

Contact Number

Emergency Number

Emergency Contact Person

Parent's Details

Parent's Name

Parent Address

City

State

Zip Code

Parent Number

Lifestyle (optional)

Tobacco:

Yes No

Coffee:

Yes No

Alcohol:

Yes No

Recreational Drugs:

Yes No

Counseling:

Yes No

Exercise Patterns:

Yes No

Hazardous Activities:

Yes No

Sleep Patterns:

Yes No

Seatbelt Use:

Yes No

Risk Factors: (optional)

- [ ] Hypertension
- [ ] Diabetes
- [ ] Sickle Cell
- [ ] Fibroids
- [ ] PID (Pelvic Inflammatory Disease)
- [ ] Severe Migraine
- [ ] Heart Disease
- [ ] Thrombosis/Stroke
- [ ] Hepatitis
- [ ] Gall Bladder Condition
- [ ] Breast Disease
- [ ] Depression

- [ ] Allergies
- [ ] Infertility
- [ ] Asthma
- [ ] Epilepsy
- [ ] Contact Lenses
- [ ] Contraceptive Complication (specify)
- [ ] Varicose Veins

Medical Condition

List any medical conditions that you have been diagnosed with (Check all that apply)

- [ ] Type 2 Diabetes
- [ ] High Blood Pressure (Hypertension)
- [ ] High Cholesterol
- [ ] Sleep Apnea
- [ ] Heart Disease including abnormal heart rhythm, heart failure, or stroke
- [ ] Diseases of the Breast, Ovaries, or Uterus
- [ ] Diseases of the testes or prostate (Enlarged Prostate or Prostate Cancer)
- [ ] Erectile dysfunction or decreased libido (sex drive)
- [ ] History of Priapism (erection lasting longer than 4 hours while on medication)
- [ ] Hair loss of the scalp
- [ ] Gastrointestinal disorders (stomach ulcers, gastroparesis, inflammatory bowel disease)
- [ ] Pancreatitis or pancreatic disease
- [ ] Personal or Family history of Thyroid Cancer
- [ ] Personal or Family History of Multiple Endocrine Neoplasia syndrome type 2 (MEN2)
- [ ] Kidney disease or impaired kidney function
- [ ] Liver or gallbladder disease
- [ ] Psychiatric illness including eating disorders or body dysmorphia
- [ ] Abnormalities of the blood (Sickle cell anemia, leukemia, blood clots, etc)

Others (List)

List any prescription medications or herbal supplements that you are currently taking (Check all that apply)

- [ ] Medication containing nitrates (Nitroglycerin, Isosorbide mononitrate, Imdur)
- [ ] Alpha blockers (doxazosin/Cardura, prazosin/Minipress, terazosin/Hytrin)
- [ ] Aspirin
- [ ] Sildenafil (Revatio)
- [ ] Riociguat (Adempas)

Other (List)

Previous GLP-1 Use (past use including dates and doses)

Are you pregnant, planning to become pregnant, or breastfeeding?

Known allergies (medications, supplements, environmental)

Surgeries

Recreational drug use

Family history (optional)

Father

Mother

Siblings

Spouse

Offspring

Relatives (optional)

Cancer:	☐ Father	☐ Mother	☐ Sibling	☐ Spouse	☐ Offspring
Tuberculosis:	☐ Father	☐ Mother	☐ Sibling	☐ Spouse	☐ Offspring
Diabetes:	☐ Father	☐ Mother	☐ Sibling	☐ Spouse	☐ Offspring
High Blood Pressure:	☐ Father	☐ Mother	☐ Sibling	☐ Spouse	☐ Offspring
Heart Problems:	☐ Father	☐ Mother	☐ Sibling	☐ Spouse	☐ Offspring
Stroke:	☐ Father	☐ Mother	☐ Sibling	☐ Spouse	☐ Offspring
Epilepsy:	☐ Father	☐ Mother	☐ Sibling	☐ Spouse	☐ Offspring
MentalIllness:	☐ Father	☐ Mother	☐ Sibling	☐ Spouse	☐ Offspring
Suicide:	☐ Father	☐ Mother	☐ Sibling	☐ Spouse	☐ Offspring

Stats (optional)

Language

Ethinicity

Race

Family Size

Employer (optional)

Occupation

Employer Name

Employer Address

City

State

Postal Code

Country

HEALTH — ADD HEALTH RECORD

Doctor Name

Contact Number

Last Seen (DD-MM-YYYY)

Additional Problem

Lab/Diagnostic Result

Current Medication Taken

Prescription

INSURANCE — ADD INSURANCE

Company *

Bin

Policy Number

Group Number

Policy Start Date (DD-MM-YYYY)

Policy End Date (DD-MM-YYYY)

Policy Coverage *