Health Partners Plans

Medical Record Keeping Aid

Patient Name: _____

Date of Birth: ____/____/_____

Medication/Allergies: _____

Problem (Chronic/Recurrent)	Date	Problem (Chronic/Recurrent)	Date

Past Medical History (hospitalizations, past surgeries, medical illnesses)	Date

Immunizations	Date

Medications	Dosage	Date	D/C

Note: this is a suggested format identifying elements for meeting medical record standards for completed problem list, past medical history, medications and immunizations. This sample form is provided as a tool and not a requirement. Feel free to use or adapt it to the individual needs of your office.