



CHARLIE CRIST
GOVERNOR

HOLLY BENSON
SECRETARY

Florida Personal Health Record Checklist	
Administrative Data Elements	Clinical Data Elements
<input type="checkbox"/> Social Security Number	<input type="checkbox"/> Medical history
<input type="checkbox"/> Full Name (First, Middle, Last)	<input type="checkbox"/> Chronic diseases (problem list)
<input type="checkbox"/> Date of Birth	<input type="checkbox"/> Chronic disease therapies
<input type="checkbox"/> Gender	<input type="checkbox"/> Hospital visit(s) – Hospital name
<input type="checkbox"/> Primary phone number	<input type="checkbox"/> Date of hospital visit
<input type="checkbox"/> Home Address	<input type="checkbox"/> Admitting diagnosis:
<input type="checkbox"/> City, zip code, county, state of residence	<input type="checkbox"/> Prescriptions (including: medications, herbal medications, oxygen, medical equipment)
<input type="checkbox"/> Next of kin - Relationship to patient	<input type="checkbox"/> Lab Reports
<input type="checkbox"/> Full Name (First, Last and Middle)	<input type="checkbox"/> Physician who ordered the lab test(s)
<input type="checkbox"/> Gender	<input type="checkbox"/> Type of lab test ordered
<input type="checkbox"/> Address	<input type="checkbox"/> Date of lab tests,
<input type="checkbox"/> City, zip code, county, state of residence	<input type="checkbox"/> Results of lab tests, with test values
<input type="checkbox"/> Primary phone number	<input type="checkbox"/> Allergies
<input type="checkbox"/> Legal guardian of child under 18 -	<input type="checkbox"/> Drug allergy
<input type="checkbox"/> Full Name (First, Last and Middle)	<input type="checkbox"/> Severity or Type of Reaction
<input type="checkbox"/> Gender	<input type="checkbox"/> Food allergy
<input type="checkbox"/> Address	<input type="checkbox"/> Severity or Type of Reaction
<input type="checkbox"/> City, zip code, county, state of residence	<input type="checkbox"/> Other allergies
<input type="checkbox"/> Primary phone number	<input type="checkbox"/> Child's Immunizations
<input type="checkbox"/> Insurance or Health Plan	<input type="checkbox"/> Diphtheria, tetanus, and pertussis vaccine
<input type="checkbox"/> Advance Directives	<input type="checkbox"/> Measles, mumps, and rubella vaccine
<input type="checkbox"/> Physician	<input type="checkbox"/> Polio vaccine
<input type="checkbox"/> Full Name (First and Last)	<input type="checkbox"/> Chickenpox (Varicella) vaccine
<input type="checkbox"/> Telephone Number	<input type="checkbox"/> Adult immunization status
<input type="checkbox"/> Doctor's specialization	<input type="checkbox"/> Influenza (flu)
<input type="checkbox"/> Location of physician's office	<input type="checkbox"/> Tetanus/pertussis
<input type="checkbox"/> Date of last encounter with doctor	<input type="checkbox"/> Date of last tetanus shot

