



# PERSONAL HEALTH PLANNER

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Everything you need to manage your health,  
organized in one easy place.

Name:



*A well-organized health record makes it easier for the people you love  
to help you when it matters most.*

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# EMERGENCY INFORMATION SHEET

## ALLERGIES & CONDITIONS

Current allergies: \_\_\_\_\_

Chronic conditions: \_\_\_\_\_

Other notes: \_\_\_\_\_

## CURRENT MEDICATIONS

Medication 1: \_\_\_\_\_ Medication 3: \_\_\_\_\_

Medication 2: \_\_\_\_\_ Medication 4: \_\_\_\_\_

Medication 5: \_\_\_\_\_ Medication 6: \_\_\_\_\_

## EMERGENCY CONTACTS

Primary Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Secondary Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship / Notes: \_\_\_\_\_

## INSURANCE & HOSPITAL INFO

Insurance Provider: \_\_\_\_\_ Group #: \_\_\_\_\_

Member ID: \_\_\_\_\_ Preferred Hospital: \_\_\_\_\_

Policy / Notes: \_\_\_\_\_

## BLOOD TYPE, ORGAN DONOR & DNR

Blood Type: \_\_\_\_\_ Organ Donor? ☐ Yes ☐ No

**DNR Status:** ☐ I do not wish to be resuscitated.

☐ I do wish to be resuscitated.



# PATIENT MEDICAL HISTORY FORM

Full Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

## PAST MEDICAL CONDITIONS

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## PAST MEDICAL SURGERIES

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## FAMILY MEDICAL HISTORY

Condition: \_\_\_\_\_ Family Member: \_\_\_\_\_

Condition: \_\_\_\_\_ Family Member: \_\_\_\_\_

Notes: \_\_\_\_\_

## VACCINATION RECORD

| Date Given | Vaccine Name | Date for Next Dose |
|------------|--------------|--------------------|
| _____      | _____        | _____              |
| _____      | _____        | _____              |
| _____      | _____        | _____              |
| _____      | _____        | _____              |

## PHARMACY INFORMATION

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

## PRIMARY CARE DOCTOR

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

## BLOOD DRAW / LAB CENTER

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

## SPECIALIST INFORMATION

| Name  | Specialty | Address | Phone |
|-------|-----------|---------|-------|
| _____ | _____     | _____   | _____ |
| _____ | _____     | _____   | _____ |
| _____ | _____     | _____   | _____ |



# HEALTHCARE LOGIN INFORMATION

Keep this page private and secure

## HEALTHCARE PROVIDER PORTAL 1

Name: \_\_\_\_\_ Web link: \_\_\_\_\_  
Username: \_\_\_\_\_ Password: \_\_\_\_\_  
Email: \_\_\_\_\_ PIN/Code: \_\_\_\_\_  
Security Question: \_\_\_\_\_ Answer: \_\_\_\_\_

## HEALTHCARE PROVIDER PORTAL 2

Name: \_\_\_\_\_ Web link: \_\_\_\_\_  
Username: \_\_\_\_\_ Password: \_\_\_\_\_  
Email: \_\_\_\_\_ PIN/Code: \_\_\_\_\_  
Security Question: \_\_\_\_\_ Answer: \_\_\_\_\_

## PHARMACY PORTAL

Name: \_\_\_\_\_ Web link: \_\_\_\_\_  
Username: \_\_\_\_\_ Password: \_\_\_\_\_  
Email: \_\_\_\_\_ Rx Account #: \_\_\_\_\_  
Notes: \_\_\_\_\_

## INSURANCE / MEDICARE PORTAL

Name: \_\_\_\_\_ Web link: \_\_\_\_\_  
Username: \_\_\_\_\_ Password: \_\_\_\_\_  
Email: \_\_\_\_\_ Member ID: \_\_\_\_\_  
Group Number: \_\_\_\_\_ Notes: \_\_\_\_\_

Security note: Store passwords securely. Consider a password manager and share access only with trusted agents named in your Healthcare POA.



# HOSPITALIZATION & SURGERY RECORDS

Admission Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

Hospital: \_\_\_\_\_ Address: \_\_\_\_\_

Type of Admission: ☐ Emergency ☐ Planned ☐ Transfer

Reason for Admission: \_\_\_\_\_

Official Diagnosis: \_\_\_\_\_

Surgery / Procedure Details: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Surgeon Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Specialist Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Specialist Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Discharge Destination: ☐ Home ☐ Rehab ☐ Skilled Nursing ☐ Other: \_\_\_\_\_

Activity Restrictions: \_\_\_\_\_

Dietary Restrictions: \_\_\_\_\_

Medication Changes: \_\_\_\_\_

Follow-up Appt Info: \_\_\_\_\_

Tests / Imaging Ordered: \_\_\_\_\_

## Notes:

Records on Portal? ☐ Yes ☐ No Portal Info: \_\_\_\_\_



## LAB & IMAGING RECORDS

### TEST / IMAGING #1

Date: \_\_\_\_\_

Type of Test: \_\_\_\_\_

Reason for Ordering: \_\_\_\_\_

Ordering Physician: \_\_\_\_\_ Location: \_\_\_\_\_

Notes / Results: \_\_\_\_\_

Follow-Up? ☐ Yes ☐ No

### TEST / IMAGING #2

Date: \_\_\_\_\_

Type of Test: \_\_\_\_\_

Reason for Ordering: \_\_\_\_\_

Ordering Physician: \_\_\_\_\_ Location: \_\_\_\_\_

Notes / Results: \_\_\_\_\_

Follow-Up? ☐ Yes ☐ No

### TEST / IMAGING #3

Date: \_\_\_\_\_

Type of Test: \_\_\_\_\_

Reason for Ordering: \_\_\_\_\_

Ordering Physician: \_\_\_\_\_ Location: \_\_\_\_\_

Notes / Results: \_\_\_\_\_

Follow-Up? ☐ Yes ☐ No

### TEST / IMAGING #4

Date: \_\_\_\_\_

Type of Test: \_\_\_\_\_

Reason for Ordering: \_\_\_\_\_

Ordering Physician: \_\_\_\_\_ Location: \_\_\_\_\_

Notes / Results: \_\_\_\_\_

Follow-Up? ☐ Yes ☐ No



# BEFORE APPOINTMENT CHECKLIST

*"Plan for what is difficult while it is easy, do what is great while it is small." — Sun Tzu*

- ☐ Confirm appointment details (time, location, parking, telehealth link)
- ☐ Confirm any test/lab results have been received prior to appointment
- ☐ Pack hearing aids, glasses, mobility aids or other assistive devices
- ☐ Gather your insurance card, ID, and any other required paperwork
- ☐ Write down any symptoms relevant to the appointment
- ☐ Note any recent changes in your health (sleep, mood, appetite, etc.)
- ☐ Bring results from at-home checks (blood sugar logs, BP readings, etc.)
- ☐ Make a list of top 2–3 questions or concerns you want answered
- ☐ Write down preventative care questions (vaccines, screenings, etc.)
- ☐ Wear comfortable, easy-to-remove clothing for examinations
- ☐ Have Medication Log up to date
- ☐ Have a family member or trusted person scheduled to attend (if desired)

## Personal notes / additional items:

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## APPOINTMENT LOG

Date: \_\_\_\_\_ Reason for visit: \_\_\_\_\_

Location: \_\_\_\_\_ Doctor: \_\_\_\_\_

Contact Info: \_\_\_\_\_ Address: \_\_\_\_\_

**Notes Prior to Appointment:**

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**Notes During Appointment:**

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Follow Up? ☐ Yes ☐ No If Yes — Date: \_\_\_\_\_ Time: \_\_\_\_\_

Date: \_\_\_\_\_ Reason for visit: \_\_\_\_\_

Location: \_\_\_\_\_ Doctor: \_\_\_\_\_

Contact Info: \_\_\_\_\_ Address: \_\_\_\_\_

**Notes Prior to Appointment:**

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**Notes During Appointment:**

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Follow Up? ☐ Yes ☐ No If Yes — Date: \_\_\_\_\_ Time: \_\_\_\_\_

*"Beautiful young people are accidents of nature, but beautiful old people are works of art." — Eleanor Roosevelt*



## AFTER APPOINTMENT CHECKLIST

- ☐ Review notes or paperwork from your doctor before leaving
- ☐ Make sure you understand your diagnosis or treatment plan
- ☐ Ask for written instructions if you didn't receive them
- ☐ Confirm when you should return for a follow-up visit
- ☐ Double-check any medication changes (dosage, frequency, etc.)
- ☐ Schedule lab tests, imaging, or specialist referrals if ordered
- ☐ Add new medications or instructions to your Medication Log
- ☐ Mark your calendar with new appointments, tests, or reminders
- ☐ Arrange transportation if a future visit requires it
- ☐ Call your pharmacy to ensure prescriptions have been received
- ☐ Share updates with a caregiver, family member, or trusted friend
- ☐ Reflect: Did all your questions get answered? If not, write them down
- ☐ Track any new symptoms or side effects that appear after the visit
- ☐ Keep paperwork, test orders, and instructions together in a folder

### Personal notes / follow-up items:

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# MEDICATION LOG

## MEDICATION 1

Name: \_\_\_\_\_ Date Started: \_\_\_\_\_  
Generic: \_\_\_\_\_ What is this treating? \_\_\_\_\_  
Dose: \_\_\_\_\_ Times/Day: \_\_\_\_\_ Take with food? \_\_\_\_\_  
Total Duration: \_\_\_\_\_ Other Notes: \_\_\_\_\_

## MEDICATION 2

Name: \_\_\_\_\_ Date Started: \_\_\_\_\_  
Generic: \_\_\_\_\_ What is this treating? \_\_\_\_\_  
Dose: \_\_\_\_\_ Times/Day: \_\_\_\_\_ Take with food? \_\_\_\_\_  
Total Duration: \_\_\_\_\_ Other Notes: \_\_\_\_\_

## MEDICATION 3

Name: \_\_\_\_\_ Date Started: \_\_\_\_\_  
Generic: \_\_\_\_\_ What is this treating? \_\_\_\_\_  
Dose: \_\_\_\_\_ Times/Day: \_\_\_\_\_ Take with food? \_\_\_\_\_  
Total Duration: \_\_\_\_\_ Other Notes: \_\_\_\_\_

## MEDICATION 4

Name: \_\_\_\_\_ Date Started: \_\_\_\_\_  
Generic: \_\_\_\_\_ What is this treating? \_\_\_\_\_  
Dose: \_\_\_\_\_ Times/Day: \_\_\_\_\_ Take with food? \_\_\_\_\_  
Total Duration: \_\_\_\_\_ Other Notes: \_\_\_\_\_

## MEDICATION 5

Name: \_\_\_\_\_ Date Started: \_\_\_\_\_  
Generic: \_\_\_\_\_ What is this treating? \_\_\_\_\_  
Dose: \_\_\_\_\_ Times/Day: \_\_\_\_\_ Take with food? \_\_\_\_\_  
Total Duration: \_\_\_\_\_ Other Notes: \_\_\_\_\_



# COMMUNICATION LOG

Track conversations with providers, insurance, and others

## CALL / MESSAGE #1

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Rep Name: \_\_\_\_\_

Company / Department: \_\_\_\_\_

Summary of Call: \_\_\_\_\_

\_\_\_\_\_

Next Steps: \_\_\_\_\_

## CALL / MESSAGE #2

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Rep Name: \_\_\_\_\_

Company / Department: \_\_\_\_\_

Summary of Call: \_\_\_\_\_

\_\_\_\_\_

Next Steps: \_\_\_\_\_

## CALL / MESSAGE #3

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Rep Name: \_\_\_\_\_

Company / Department: \_\_\_\_\_

Summary of Call: \_\_\_\_\_

\_\_\_\_\_

Next Steps: \_\_\_\_\_

## CALL / MESSAGE #4

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Rep Name: \_\_\_\_\_

Company / Department: \_\_\_\_\_

Summary of Call: \_\_\_\_\_

\_\_\_\_\_

Next Steps: \_\_\_\_\_



# INSURANCE TRACKER

## PLAN 1

Insurance Company: \_\_\_\_\_ Plan Name: \_\_\_\_\_

Member ID: \_\_\_\_\_ Group Number: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Renewal Date: \_\_\_\_\_

Annual Deductible: \_\_\_\_\_ How much has been met? \_\_\_\_\_

Out-of-pocket max: \_\_\_\_\_ Customer Service #: \_\_\_\_\_

Primary Care Copay: \_\_\_\_\_ Specialist: \_\_\_\_\_ Urgent Care: \_\_\_\_\_

Prescription Coverage / Notes: \_\_\_\_\_

## PLAN 2

Insurance Company: \_\_\_\_\_ Plan Name: \_\_\_\_\_

Member ID: \_\_\_\_\_ Group Number: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Renewal Date: \_\_\_\_\_

Annual Deductible: \_\_\_\_\_ How much has been met? \_\_\_\_\_

Out-of-pocket max: \_\_\_\_\_ Customer Service #: \_\_\_\_\_

Primary Care Copay: \_\_\_\_\_ Specialist: \_\_\_\_\_ Urgent Care: \_\_\_\_\_

Prescription Coverage / Notes: \_\_\_\_\_

## PLAN 3

Insurance Company: \_\_\_\_\_ Plan Name: \_\_\_\_\_

Member ID: \_\_\_\_\_ Group Number: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Renewal Date: \_\_\_\_\_

Annual Deductible: \_\_\_\_\_ How much has been met? \_\_\_\_\_

Out-of-pocket max: \_\_\_\_\_ Customer Service #: \_\_\_\_\_

Primary Care Copay: \_\_\_\_\_ Specialist: \_\_\_\_\_ Urgent Care: \_\_\_\_\_

Prescription Coverage / Notes: \_\_\_\_\_



# BILLING TRACKER

## SERVICE

Service Provided: \_\_\_\_\_

Date of Service: \_\_\_\_\_

Provider / Facility: \_\_\_\_\_

Amount Billed: \_\_\_\_\_

Amount Insurance Covered: \_\_\_\_\_

Amount You Paid: \_\_\_\_\_

Payment Method & Date: \_\_\_\_\_

Additional Notes: \_\_\_\_\_

## SERVICE

Service Provided: \_\_\_\_\_

Date of Service: \_\_\_\_\_

Provider / Facility: \_\_\_\_\_

Amount Billed: \_\_\_\_\_

Amount Insurance Covered: \_\_\_\_\_

Amount You Paid: \_\_\_\_\_

Payment Method & Date: \_\_\_\_\_

Additional Notes: \_\_\_\_\_

## SERVICE

Service Provided: \_\_\_\_\_

Date of Service: \_\_\_\_\_

Provider / Facility: \_\_\_\_\_

Amount Billed: \_\_\_\_\_

Amount Insurance Covered: \_\_\_\_\_

Amount You Paid: \_\_\_\_\_

Payment Method & Date: \_\_\_\_\_

Additional Notes: \_\_\_\_\_

## SERVICE

Service Provided: \_\_\_\_\_

Date of Service: \_\_\_\_\_

Provider / Facility: \_\_\_\_\_

Amount Billed: \_\_\_\_\_

Amount Insurance Covered: \_\_\_\_\_

Amount You Paid: \_\_\_\_\_

Payment Method & Date: \_\_\_\_\_

Additional Notes: \_\_\_\_\_



# WELLNESS & PREVENTATIVE CARE TRACKER

*"You are never too old to set another goal or to dream a new dream." — C.S. Lewis*

## VACCINATION STATUS

Are you up to date on all recommended vaccinations?

☐ Yes

☐ No

Notes / last update: \_\_\_\_\_

## PREVENTATIVE SCREENINGS (last 10 years)

List screenings received and the year:

Year: \_\_\_\_\_

Year: \_\_\_\_\_

Year: \_\_\_\_\_

Year: \_\_\_\_\_

## LIFESTYLE NOTES

Average sleep, exercise, and diet throughout a typical week:

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## PERSONAL HEALTH GOALS

Goals for your health over the next few years:

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*A complete estate plan includes Healthcare Power of Attorney & Living Will — talk to Claim My Legacy.*