Health Care List

This list is from Logging My Life by Abby Brown. You are welcome to use it, and add items as needed.

Your health makes everything you do possible.

Protecting it for yourself, and your family, is the right thing to do. It isn't selfish at all.

Regardless of ablebodyness, or disability, health care issues can surprise us all. Having the following worksheets filled in, and available in an emergency situation, may save your life, or the life of a family member.

It is a good idea once a year, when planning taxes and credit checks, to verify that all allergy, medication, insurance, and doctor information is up to date.

If you have many medical disorders, especially allergies, maintaining a copy saved in your phone email may be the difference between life and death in an emergency.

Doctor List Page 1 of 3

Primary Doctor
Name: _____
Address: _____
Phone Number: _____
Hours of Operation: _____
Web Address: _____
Email Address: _____
Yearly Checkup: _____

Eye Doctor
Name: _____
Address: _____
Phone Number: _____
Hours of Operation: _____
Web Address: _____
Email Address: _____
Yearly Checkup: _____

Doctor - Ear, Nose, and Throat
Name: _____
Address: _____
Phone Number: _____
Hours of Operation: _____
Web Address: _____
Email address: _____
Yearly Checkup: _____

Doctor List Page 2 of 3

Dentist
Name: _____
Address: _____
Phone Number: _____
Hours of Operation: _____
Web Address: _____
Email Address: _____
Yearly Checkup: _____

Oral Surgeon
Name: _____
Address: _____
Phone Number: _____
Hours of Operation: _____
Web Address: _____
Email Address: _____
Yearly Checkup: _____

Doctor
Name: _____
Address: _____
Phone Number: _____
Hours of Operation: _____
Web Address: _____
Email address: _____
Yearly Checkup: _____

Doctor List Page 3 of 3

Doctor
Name: _____
Address: _____
Phone Number: _____
Hours of Operation: _____
Web Address: _____
Email Address: _____
Yearly Checkup: _____

Doctor
Name: _____
Address: _____
Phone Number: _____
Hours of Operation: _____
Web Address: _____
Email Address: _____
Yearly Checkup: _____

Doctor
Name: _____
Address: _____
Phone Number: _____
Hours of Operation: _____
Web Address: _____
Email Address: _____
Yearly Checkup: _____

Immunizations, Certifications

Immunizations

Date: **Type:** **Location:**

Certifications (CPR, First Aid)

Date Granted: **Type:** **Date Expires:**

Exams (Dexa Scan, Mammogram)

Date:	Type:	Location:	Frequency:

Hospitalizations

Allergies

Type: **Onset:** **Symptoms:**

Environmental Allergies:

Food Allergies

Medicine Allergies

Type:	Onset:	Symptoms:

Diagnosis

Diagnosis:	Doctor:	Diagnosis Date:

Physical Symptom, Duration, and Intensity

Symptom: ___________________
Duration: ___________________
Intensity: 1 2 3 4 5 6 7 8 9 10

Symptom: ___________________
Duration: ___________________
Intensity: 1 2 3 4 5 6 7 8 9 10

Symptom: ___________________
Duration: ___________________
Intensity: 1 2 3 4 5 6 7 8 9 10

Symptom: ___________________
Duration: ___________________
Intensity: 1 2 3 4 5 6 7 8 9 10

Symptom: ___________________
Duration: ___________________
Intensity: 1 2 3 4 5 6 7 8 9 10

Symptom: ___________________
Duration: ___________________
Intensity: 1 2 3 4 5 6 7 8 9 10

Symptom: ___________________
Duration: ___________________
Intensity: 1 2 3 4 5 6 7 8 9 10

Symptom: ___________________
Duration: ___________________
Intensity: 1 2 3 4 5 6 7 8 9 10

Mental Symptoms, Duration, and Intensity

Symptom: _____
Duration: _____
Intensity: 1 2 3 4 5 6 7 8 9 10

Symptom: _____
Duration: _____
Intensity: 1 2 3 4 5 6 7 8 9 10

Symptom:_____
Duration: _____
Intensity: 1 2 3 4 5 6 7 8 9 10

Symptom: _____
Duration: _____
Intensity: 1 2 3 4 5 6 7 8 9 10

Symptom: _____
Duration: _____
Intensity: 1 2 3 4 5 6 7 8 9 10

Symptom: _____
Duration: _____
Intensity: 1 2 3 4 5 6 7 8 9 10

Symptom: _____
Duration: _____
Intensity: 1 2 3 4 5 6 7 8 9 10

Symptom: _____
Duration: _____
Intensity: 1 2 3 4 5 6 7 8 9 10

Medical Insurance Page 1 of 3

Medical Insurance Information: (Primary)

Name: _____
Address: _____
Phone Number: _____
Web Address: _____
Email Address: _____
Co-Pay: _____
Valid Dates: _____
Account Information: _____

Medical Insurance Information: (Secondary - May include Medicaid or Medicare)

Name: _____
Address: _____
Phone Number: _____
Web Address: _____
Email Address: _____
Co-Pay: _____
Valid Dates: _____
Account Information: _____

Dental Insurance Information:
Name: _____
Address: _____
Phone Number: _____
Web Address: _____
Email Address: _____
Co-Pay: _____
Valid Dates: _____
Account Information: _____

Medical Insurance Page 2 of 3

Vision Insurance Information:

Name: _____
Address: _____
Phone Number: _____
Web Address: _____
Email Address: _____
Co-Pay: _____
Valid Dates: _____
Account Information: _____
Chiropractic Insurance Information:

Name: _____
Address: _____
Phone Number: _____
Web Address: _____
Email Address: _____
Co-Pay: _____
Valid Dates: _____
Account Information: _____

Disability Insurance Information:

Name: _____
Address: _____
Phone Number: _____
Web Address: _____
Email Address: _____
Co-Pay: _____
Valid Dates: _____
Account Information: _____

Medical Insurance Page 3 of 3

Life Insurance Information:

Name: _____
Address: _____
Phone Number: _____
Web Address: _____
Email Address: _____
Co-Pay: _____
Valid Dates: _____
Account Information: _____

Current Medications Page 1 of 2

Name, milligrams and times per day, include over the counter meds such as calcium and multi vitamins.

Person's Name _____

Medication Name:	Amount:	Frequency:	Refill:

Current Medications Page 2 of 2

Name, milligrams and times per day, include over the counter meds such as calcium and multi vitamins.

Person's Name _____

Medication Name:	Amount:	Frequency:	Refill:

Pharmacy

Pharmacy: _____
Name: _____
Address: _____
Hours of Operation: _____
Phone Number: _____
Web Address: _____
Email Address: _____

Online Pharmacy (for long term medications)

Pharmacy: _____
Name: _____
Address: _____
Hours of Operation: _____
Phone Number: _____
Web Address: _____
Email Address: _____