***Welcome to your medical binder!***

This binder was created to help you keep all your medical information in one accessible spot.  Fill out as much of the binder as you can so that you and your doctors can easily keep track of your medical history. We included some extra pages for the binder in case you run out of room, but if you need more pages, you can find them on the Godman Guild website (www.godmanguild.org) under Health and Wellness. If you do not have access to the internet, go to the Godman Guild and request pages.

We will contact you in a few months to see how this is working for you.

*This medical binder was brought to you by students of The Ohio State University College of Medicine, in partnership with the Godman Guild Association.*





IF FOUND, PLEASE CONTACT

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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|  | **2017 Appointments** |  |  |  |  |
|  | **Sunday** | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** |
| JUL |   |   |   |   |   |   | 1 |
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| 31 |   |   |   |   |   |   |
|  | **2018 Appointments** |  |  |  |  |
|  | **Sunday** | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** |
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| FEB | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
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| 25 | 26 | 27 | 28 | 1 | 2 | 3 |
| MAR | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
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| 18 | 19 | 20 | 21 | 22 | 23 | 24 |
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| APR | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
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| 29 | 30 | 1 | 2 | 3 | 4 | 5 |
| MAY | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
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| JUN | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 10 | 11 | 12 | 13 | 14 | 15 | 16 |
| 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| 24 | 25 | 26 | 27 | 28 | 29 | 30 |

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**Medications Section 4**

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**Personal and Contact Information**

**Personal Information** **Health Insurance Information**

Name: Insured? Y N

Date of Birth: Company:

Address: Policy #:

 Phone #:

Phone #:

 **Primary Physician Information**

**Emergency Contact #1** Name:

Name: Address:

Relationship:

Phone #: Phone #:

**Emergency Contact #2** **Dentist Information**

Name: Name:

Relationship: Address:

Phone #:

 Phone #:

**Emergency Contact #3**

Name: **Pharmacy Information**

Relationship: Pharmacy Name:

Phone #: Address:

 Phone #:

**Person Authorized to Make Decisions in the Case You Are Unable**

Name: Phone #:

**Personal and Contact Information**

**Personal Information** **Health Insurance Information**

Name: Insured? Y N

Date of Birth: Company:

Address: Policy #:

 Phone #:

Phone #:

 **Primary Physician Information**

**Emergency Contact #1** Name:

Name: Address:

Relationship:

Phone #: Phone #:

**Emergency Contact #2** **Dentist Information**

Name: Name:

Relationship: Address:

Phone #:

 Phone #:

**Emergency Contact #3**

Name: **Pharmacy Information**

Relationship: Pharmacy Name:

Phone #: Address:

 Phone #:

**Person Authorized to Make Decisions in the Case You Are Unable**

Name: Phone #:

**Past Medical History**

|  |  |
| --- | --- |
| **Blood Type** |  |

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| --- | --- | --- | --- |
| Health Conditions | Date of Diagnosis | Past Surgeries or Procedures | Date |
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| Allergies | Reaction | Past Injuries | Date |
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**Past Hospitalizations**

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| Date | Reason | Additional Notes |
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**Medications**

*If you experience any side effects, please note them in the Health Journal under the Current Health Section and report them to your doctor.*

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| Medication | Dose | Frequency | Start | End |
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**Medications**

*If you experience any side effects, please note them in the Health Journal under the Current Health Section and report them to your doctor.*

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**Family History**

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| --- | --- | --- | --- | --- |
| Relation | Name | Birthdate | Illness/Condition | Age/Cause of Death |
| Mother |  |  |  |  |
| Father |  |  |  |  |
| Maternal grandma |  |  |  |  |
| Maternal grandpa |  |  |  |  |
| Paternal grandma |  |  |  |  |
| Paternal grandpa |  |  |  |  |
| Sibling |  |  |  |  |
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**Immunization History**

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| --- | --- |
| Vaccine | Date(s) given |
| Tetanus, diphtheria, pertussis (Tdap) |  |
| Hepatitis A |  |
| Hepatitis B |  |
| Human papillomavirus (HPV) |  |
| Measles, mumps, rubella (MMR) |  |
| Varicella |  |
| Meningococcal ACWY |  |
| Meningococcal B |  |
| Pneumococcal conjugate (PCV13) |  |
| Pneumococcal polysaccharide (PPSV23) |  |
| Zoster (HZV) |  |
| *Haemophilus influenza type b* (Hib) |  |
| Influenza |  |
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**Care Team**

**Primary Care Physician Specialist**

Name: Name:

Address: Address:

Phone #: Phone #:

**Specialist Specialist**

Name: Name:

Address: Address:

Phone #: Phone #:

**Specialist Specialist**

Name: Name:

Address: Address:

Phone #: Phone #:

**Specialist Specialist**

Name: Name:

Address: Address:

Phone #: Phone #:

**Specialist Specialist**

Name: Name:

Address: Address:

Phone #: Phone #:

**Specialist Specialist**

Name: Name:

Address: Address:

Phone #: Phone #:

**Doctor’s Visits**

Date:

Seen by:

Reason for visit:

Notes:

Date:

Seen by:

Reason for visit:

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Date:

Seen by:

Reason for visit:

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Seen by:

Reason for visit:

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**Doctor’s Visits**

Date:

Seen by:

Reason for visit:

Notes:

Date:

Seen by:

Reason for visit:

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Date:

Seen by:

Reason for visit:

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Seen by:

Reason for visit:

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**Phone Calls**

Date:

Seen by:

Reason for visit:

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Reason for visit:

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Reason for visit:

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Reason for visit:

Notes:

**Health Journal**

**Instructions**: *Please use this space to document your observations about your daily health. This includes any symptoms you’ve been experiencing, when they started, how often they occur, when they occur, and any other descriptive detail.*

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**Concerns and Questions**

**Instructions**: *Please use this space to document any questions or notes you want to make sure to discuss at your next visit with your primary care physician or any other specialist.*

**Concerns and Questions**

**Instructions**: *Please use this space to document any questions or notes you want to make sure to discuss at your next visit with your primary care physician or any other specialist.*

**Weight Tracker**

*Note: Weighing yourself first thing in the morning will provide you with the most accurate read on your weight, but if the morning doesn’t work, make sure you weigh yourself at the same time, and on the same scale, to keep things consistent.*

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**Weight Tracker**

*Note: Weighing yourself first thing in the morning will provide you with the most accurate read on your weight, but if the morning doesn’t work, make sure you weigh yourself at the same time, and on the same scale, to keep things consistent.*

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**Blood Pressure Tracker**

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|  | Systolic | Diastolic |
| Target blood pressure |  |  |

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| Date | Time (a.m.) | Blood Pressure | Time (p.m.) | Blood Pressure | Comments |
| *Sample: 4/1/17* | *8:20* | *137/87* | *8:24* | *150/90* | *Stressful day at work* |
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**Blood Pressure Tracker**

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|  | Systolic | Diastolic |
| Target blood pressure |  |  |

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| --- | --- | --- | --- | --- | --- |
| Date | Time (a.m.) | Blood Pressure | Time (p.m.) | Blood Pressure | Comments |
| *Sample: 4/1/17* | *8:20* | *137/87* | *8:24* | *150/90* | *Stressful day at work* |
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**Blood Sugar Diary**

*Test your blood sugar before and after meals (either 1 or 2 hours after). Use the* ***notes*** *section to record* ***exercise****,* ***illnesses****, periods of* ***stress****, or* ***delayed or missed meals*** *during the day, as they can affect sugar levels. If a day needs a lot of notes, put an asterisk \* or a number (e.g. 2) in the notes for that day and write the notes on the back of the diary sheet.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date** | **Morning/Breakfast** | **Midday/Lunch** | **Evening/Dinner** | **Notes** |
| **Pre meal** | **Post meal** | **Pre meal** | **Post meal** | **Pre meal** | **Post meal** |
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**Blood Sugar Diary**

*Test your blood sugar before and after meals (either 1 or 2 hours after). Use the* ***notes*** *section to record* ***exercise****,* ***illnesses****, periods of* ***stress****, or* ***delayed or missed meals*** *during the day, as they can affect sugar levels. If a day needs a lot of notes, put an asterisk \* or a number (e.g. 2) in the notes for that day and write the notes on the back of the diary sheet.*

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| --- | --- | --- | --- | --- |
| **Date** | **Morning/Breakfast** | **Midday/Lunch** | **Evening/Dinner** | **Notes** |
| **Pre meal** | **Post meal** | **Pre meal** | **Post meal** | **Pre meal** | **Post meal** |
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**Health Documents**

*Please use this section to store documents received during your medical care. Some examples include:*

* *Lab results*
* *Radiology reports*
* *Hospital discharge documents*
* *Notes from clinic visits*