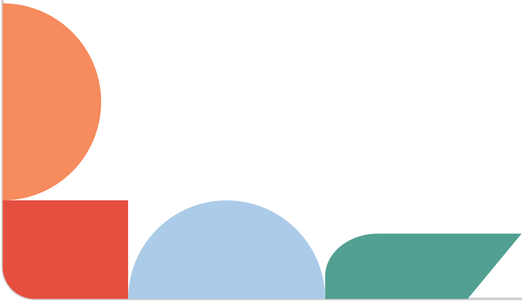
Medical Binder



Basic Health Information

First Name: ______________ Middle Name: ______________ Surname: ______________

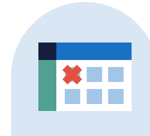
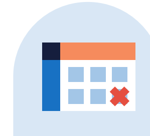
Date of Birth: ______________ Blood Type: ______________ Donor: ☐ Yes ☐ No

Allergies

Shots & Vaccinations	Date

Emergency Contact Information		
Name	Relationship	Phone Number

Medication Tracker

Medication	Dosage	Taken For	Taken in the AM	PM	Date Started	Date Ended	Prescribed By
			☐	☐			
			☐	☐			
			☐	☐			
			☐	☐			
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Blood Pressure Log

Name: ____________

Month: ____________

My blood pressure is typically fairly:

☐ High ☐ Low

Blood Pressure Key	Systolic	Diastolic
Normal	120	80
Mild Hypertension	140-160	90-100
Moderate Hypertension	160-200	100-120
Severe Hypertension	Above 200	Above 120

Date	Time	Blood Pressure	Notes
	AM		
	PM		
	AM		
	PM		
	AM		
	PM		
	AM		
	PM		
	AM		
	PM		
	AM		
	PM		
	AM		
	PM		
	AM		
	PM		
	AM		
	PM		
	AM		
	PM		
	AM		
	PM		
	AM		
	PM		

Appointment Tracker

Date	Time	Physician/Dentist/etc.	Reason for Visit	Notes

Contact Information

Emergency Contact		
Name	Phone Number	Relationship

Caregiver		
Name	Phone Number	Agency

Nearest Hospital	
Name	
Address	
Phone Number	

Primary Care Physician	
Name	
Address	
Phone Number	

Therapist	
Name	
Address	
Phone Number	

Specialty Physician	
Name	
Address	
Phone Number	

Dentist	
Name	
Phone Number	

Other	
Name	
Phone Number	

Health Tracker

Personalize this tracking sheet for your current life circumstances.

This tracker is for: ____________________

Date	Time	Description (symptom, hours of sleep, type of migraine, etc.)	Notes