Mini Medical

EMERGENCY

Information Binder

Helping you organize your health records

If you enjoyed this content, be sure to preorder Lisa's book *The Paper Solution* being released on August 4th! Preorder now at organize365.com/book.

Too many women feel overwhelmed, hopeless, and have lost the motivation to take back the organization of their homes. They weren't "born organized." Their family doesn't understand them. They have tried and tried, but nothing works. No, no, NO! Anyone can get organized! But it takes work and a new way of looking at the challenge ahead.

Organize 365® is dedicated to encouraging women to simplify their lives, increase their productivity, and live life on purpose. As a professional organizer and productivity specialist, Lisa Woodruff shares practical and humorous messages about organization and time management.

ORGANIZE 365® MISSION

Help busy women finally get their home and paper organized in one year with functional organizing systems that work.

LISA WOODRUFF

Professional Organizer

As a professional organizer & productivity expert, Lisa Woodruff has helped thousands of women reclaim their homes and finally get organized with her practical tips, encouragement, and humor through her blog and podcast, Organize 365®.

She is the creator of the online organization series: *100 Day Home Organization Challenge, Organize 101: The Sunday Basket,* and *Get ALL Your Papers Organized Solution.*

"You saved my sanity in May when I downloaded your Medical notebook guideline and completed it for my Mother. I added...surgeries, doctor appts, ER visits, hospital stays, etc. Each item is one line with date and reason. The EMTs loved it and suggested that I keep it available in her apartment along with the current medication and contact info from your Medical binder."

- Darlene

ADULT

FAMILY INFORMATION SHEET

THE BASICS

Name: ____________________ Date: ____________________

Maiden Name or Other Names: ____________________

Address: ____________________

City: ____________________ State: __________ Zip: ____________________

Home Phone: ____________________ Cell Phone: ____________________

Birthdate: ____________________ City / State of Birth: ____________________

Emergency Contact: ____________________ Phone: ____________________

Height: ____________________ Weight: ____________________ Social Security #:__________-__________-__________

Allergies: ____________________

E-mail: ____________________ 2nd Email: ____________________

ID'S

Driver's License #: ____________________ State: ____________________

Military/DoD ID: ____________________

Passport #: ____________________ Passport location: ____________________

IMPORTANT PEOPLE

Spouse's Full Name: ____________________

Father's Full Name: ____________________ Birthdate: ____________________

Mother's Full Name: ____________________ Birthdate: ____________________

Employer: ____________________

Employer Address: ____________________ Phone: ____________________

Accountant: ____________________ Phone: ____________________

Attorney: ____________________ Phone: ____________________

Doctor: ____________________ Phone: ____________________

Dentist: ____________________ Phone: ____________________

Eye Doctor: ____________________ Phone: ____________________

Other Medical Team: ____________________

____

EXTRAS

Pharmacy: ____________________ Phone: ____________________

Preferred Hospital: ____________________ Phone: ____________________

High School: ____________________ Grad Year: ____________________

College: ____________________ Grad Year:____________________

Other: ____________________ Completed:____________________

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE

Copy of Front and back of card

Carrier/Company: ____________________

Policy #: ____________________

Group #: ____________________

Customer Service: ____________________

Username: ____________________

Password: ____________________

MEDICARE PRIMARY INSURANCE

Copy of Front and back of card

Carrier/Company: ____________________

Policy #: ____________________

Group #: ____________________

Customer Service: ____________________

Username: ____________________

Password: ____________________

SUPPLEMENTAL/ SECONDARY INS.

Copy of Front and back of card

Carrier/Company: ____________________

Policy #: ____________________

Group #: ____________________

Customer Service: ____________________

Username: ____________________

Password: ____________________

MEDICAID INFORMATION

Copy of Front and back of card

Carrier/Company: ____________________

Policy #: ____________________

Group #: ____________________

Customer Service: ____________________

Username: ____________________

Password: ____________________

CHILD

FAMILY INFORMATION SHEET

THE BASICS

Name: ______________________________ Date: ______________
Address: ______________________________
City: ______________________________ State: __________ Zip: ______________
Home Phone: ______________________ Cell Phone: ______________________
Birthdate: ______________ City / State of Birth: ______________________
Emergency Contact: ______________________ Phone: ______________________
Height: ______________ Weight: ______________ Social Security #: _______-______-_______
Clothing Sizes: ______________________________ Shoe Sizes: ______________
Allergies: ______________________________

ID'S

E-mail: ______________________________
Driver's License #: ______________________________ State: ______________
Passport #: ______________________ Passport location: ______________________

IMPORTANT PEOPLE

Father's Full Name: ______________________________ Birthdate: ______________
Mother's Full Name: ______________________________ Birthdate: ______________
Doctor: ______________________________ Phone: ______________________
Dentist: ______________________________ Phone: ______________________
Eye Doctor: ______________________________ Phone: ______________________
Other Medical Team: ______________________________
____
Pharmacy: ______________________________ Phone: ______________________
Preferred Hospital: ______________________________ Phone: ______________________

EDUCATION

Primary School Name: ______________________________ Years: ______________
Address: ______________________________ Phone: ______________
Middle School Name: ______________________________ Years: ______________
Address: ______________________________ Phone: ______________
High School Name: ______________________________ Years: ______________
Address: ______________________________ Phone: ______________

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE

Copy of Front and back of card
Carrier/Company: ______________________
Policy #: ______________________
Group #: ______________________
Customer Service: ______________________
Username: ______________________
Password: ______________________

MEDICARE PRIMARY INSURANCE

Copy of Front and back of card
Carrier/Company: ______________________
Policy #: ______________________
Group #: ______________________
Customer Service: ______________________
Username: ______________________
Password: ______________________

SUPPLEMENTAL/ SECONDARY INS.

Copy of Front and back of card
Carrier/Company: ______________________
Policy #: ______________________
Group #: ______________________
Customer Service: ______________________
Username: ______________________
Password: ______________________

NOTES:

____
____
____
____
____
____
____

If you have a custody agreement for your child that specifies which parents are allowed to make medical decisions, please keep a copy of that paperwork in your medical binder. Also consider keeping a copy or a photograph on your phone.

ADULT

ONE PAGE **MEDICAL** INFORMATION SHEET

Name: ____________________

Birthdate: __________ Age: __________ Height: __________ Weight: __________

Address: ____________________

Emergency Contact: ____________________ Phone: __________

Backup Emergency Contact: ____________________ Phone: __________

Caregiver Name: ____________________ Phone: __________

Primary Doctor Name: ____________________ Phone: __________

Insurance Information: ____________________

Preferred Hospital: ____________________

Dentist: ____________________ Phone: __________

Dental Insurance Information: ____________________

OTHER IMPORTANT HEALTH CARE PROVIDERS

Name: ____________________ Phone: __________

Name: ____________________ Phone: __________

Name: ____________________ Phone: __________

MEDICAL PROBLEMS

- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________

MEDICATIONS/TREATMENTS

- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________

ALLERGIES/TO AVOID

- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________

MEDICAL EQUIPMENT (oxygen, wheelchair, etc.)

- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________

IMMUNIZATION RECORD

- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________

OTHER IMPORTANT HEALTH INFORMATION

- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________

CHILD

ONE PAGE **MEDICAL** INFORMATION SHEET

Name: ____________________

Birthdate: ____________ Age: ________ Height: ________ Weight: ________

Address: ____________________

Parent's Name: ____________________ Phone: ____________

Parent's Name: ____________________ Phone: ____________

Backup Emergency Contact: ____________________ Phone: ____________

Primary Doctor Name: ____________________ Phone: ____________

Insurance Information: ____________________

Dentist: ____________________ Phone: ____________

Dental Insurance Information: ____________________

OTHER IMPORTANT HEALTH CARE PROVIDERS

Name: ____________________ Phone: ____________

Name: ____________________ Phone: ____________

Name: ____________________ Phone: ____________

MEDICAL PROBLEMS

- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________

MEDICATIONS/TREATMENTS/IMMUNIZATIONS

- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________

ALLERGIES/FOOD OR SUBSTANCES TO AVOID

- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________

MEDICAL EQUIPMENT (oxygen, wheelchair, etc.)

- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________

FAVORITE TREATS AND REWARDS

- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________

OTHER IMPORTANT HEALTH INFORMATION

- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________

If you have a custody agreement for your child that specifies which parents are allowed to make medical decisions, please keep a copy of that paperwork in your medical binder. Also consider keeping a copy or a photograph on your phone.

MEDICAL AND **HEALTH** HISTORY

As a parent of two children with medical needs, I am at the doctor more than I am anywhere else! Taking the time to write out a brief summary of your health history can provide great clues to a new doctor.

Included in this section is a space for you to document symptoms. For example, when my son gets a cold it triggers his asthma. For my daughter, she will get a high fever and a barky cough. Knowing how a family member's symptoms typically play out is helpful to avoid panic.

In my case, a high fever in my son is cause for concern but not in my daughter. Additionally her barky cough sounds terrible, but it is her body's way of recovering.

Oddly when my daughter's verb tenses are incorrect it means her medication levels are off. *{"I hadded to go" instead of "had to go."}*

We would all like to think that medical care is black and white, but unfortunately there is lot of gray. If you are caring for a child, an older family member or someone who has lost communication, symptoms are great clues to the care they need.

CHILDHOOD AND EARLY 20'S HEALTH INFORMATION:

____

____

____

____

____

____

RESOLVED CONDITIONS / TREATMENTS IN ADULTS YEARS:

____

____

____

____

____

____

MEDICAL AND HEALTH HISTORY (CONT'D)

CURRENT CONDITIONS:

TREATMENTS THAT HAVE WORKED / NOT WORKED:

CHANGES IN BEHAVIOR AND SYMPTOMS:

FAMILY **MEDICAL** HISTORY FORM

Use this form to record any known information about your family's medical history. Include as much as information as possible. List any medical problems or issues (e.g. cancer, diabetes, high blood pressure, early death, dementia, miscarriage, autism, glaucoma, birth defects, kidney problems/dialysis, hearing loss, wearing glasses, allergies, asthma, genetic conditions, etc.)

FAMILY MEDICAL HISTORY FOR: ______________________________

PATERNAL (DAD'S) SIDE	MATERNAL (MOM'S) SIDE
Grandfather (Dad's Dad)	Grandfather (Mom's Dad)
Grandmother (Dad's Mom)	Grandmother (Mom's Mom)
Dad	Mom
Other relatives (sibling, aunt, uncle, cousin, other)	Other relatives (sibling, aunt, uncle, cousin, other)
Other relatives (sibling, aunt, uncle, cousin, other)	Other relatives (sibling, aunt, uncle, cousin, other)
Other relatives (sibling, aunt, uncle, cousin, other)	Other relatives (sibling, aunt, uncle, cousin, other)

DIAGNOSIS TRACKER

MEDICAL DIAGNOSIS	DIAGNOSTICIAN & DATE	TREATMENTS TRIED	RESULTS

MEDICATION TRACKER

MEDICATION PRESCRIBED	PRESCRIBER	EFFECTS	OTHER NOTES (e.g. dates taken, special instructions,effectiveness,etc.)