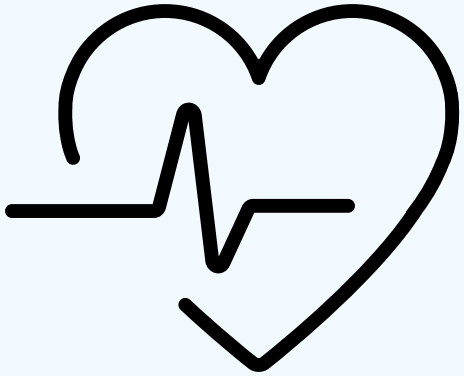
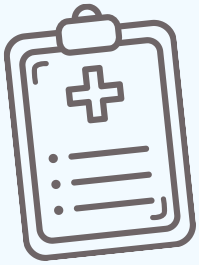
RJP ESTATE PLANNING

PERSONAL HEALTH PLANNER

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

Name: _____





EMERGENCY INFORMATION SHEET

ALLERGIES & CONDITIONS

Current allergies: _____

Chronic Conditions: _____

CURRENT MEDICATIONS

Medication 1: _____ Medication 3: _____

Medication 2: _____ Medication 4: _____

EMERGENCY CONTACTS

Primary Contact Name: _____ Phone Number: _____

Secondary Contact Name: _____ Phone Number: _____

INSURANCE & HOSPITAL INFO

Insurance Provider: _____ Group Number: _____

Member ID Number: _____ Preferred Hospital: _____

BLOOD TYPE, DONOR, DNR

Blood Type: _____ Organ Donor? **Yes** or **No**

DNR status: ____ I do not wish to be resuscitated.

____ I do wish to be resuscitated.

PATIENT MEDICAL HISTORY FORM

Full Name: _____ Address: _____

Phone Number: _____ Email: _____

PAST MEDICAL CONDITIONS

_____

_____

_____

_____

PAST MEDICAL SURGERIES

_____

_____

_____

_____

FAMILY MEDICAL HISTORY

Condition:

_____

_____

_____

Family Member Associated:

_____

_____

_____

VACCINATION RECORD

Date Given	Vaccine Name	Date for Next Dose

PHARMACY INFORMATION

Name: _____ Address: _____ Phone: _____

PRIMARY CARE DOCTOR INFO

Name: _____ Address: _____ Phone: _____

BLOOD DRAW/LAB CENTER INFO

Name: _____ Address: _____ Phone: _____

SPECIALIST INFO

Name	Specialty	Address	Phone

HEALTHCARE LOGIN INFORMATION

Healthcare Provider Portals:

Name:	Web link:
Username:	Password:
Email:	PIN/Code (if applicable):
Security Question:	Answer:

Name:	Web link:
Username:	Password:
Email:	PIN/Code (if applicable):
Security Question:	Answer:

Name:	Web link:
Username:	Password:
Email:	PIN/Code (if applicable):
Security Question:	Answer:

Pharmacy Portal:

Name:	Web link:
Username:	Password:
Email:	Prescription Account Number:
Notes:	

Insurance/Medicare Portal:

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

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

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

Date: Type of Test:

Reason for Ordering:

Ordering Physician: Location:

Notes/Results:

Follow-Up? Yes No

Date: Type of Test:

Reason for Ordering:

Ordering Physician: Location:

Notes/Results:

Follow-Up? Yes No

Date: Type of Test:

Reason for Ordering:

Ordering Physician: Location:

Notes/Results:

Follow-Up? Yes No

Date: Type of Test:

Reason for Ordering:

Ordering Physician: Location:

Notes/Results:

Follow-Up? Yes No

BEFORE APPOINTMENT CHECKLIST

"Plan for what it 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 appt.
- [ ] 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 appointment.
- [ ] Note any recent changes in your health (sleep, mood, appetite, etc.)
- [ ] Bring results from at-home checks (blood sugar logs, 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 scheduled to attend.
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____

Blank boxes are for your personal needs before your appointments.

APPOINTMENT LOG

Date: **Reason for visit:**

Location: Doctor:

Contact Info: Address:

Notes Prior to Appointment:

Notes During Appointment:

Follow Up? Yes or No If Yes: Date: Time:

Referral? Yes or No If Yes: Details:

Action Steps from Appt:

Date: **Reason for visit:**

Location: Doctor:

Contact Info: Address:

Notes Prior to Appointment:

Notes During Appointment:

Follow Up? Yes or No If Yes: Date: Time:

Referral? Yes or No If Yes: Details:

Action Steps from Appt:

"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 list.
- [ ] 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 visit.
- [ ] Keep paperwork, test orders, and instructions together in a folder.
- [ ] _____
- [ ] _____
- [ ] _____

Blank boxes are for your personal needs after your appointments.

MEDICATION LOG

Name: Date:

Generic: What is this treating?

Dose: Take with Food?

Time: Times per Day: Total Duration:

Other Notes:

Name: Date:

Generic: What is this treating?

Dose: Take with Food?

Time: Times per Day: Total Duration:

Other Notes:

Name: Date:

Generic: What is this treating?

Dose: Take with Food?

Time: Times per Day: Total Duration:

Other Notes:

Name: Date:

Generic: What is this treating?

Dose: Take with Food?

Time: Times per Day: Total Duration:

Other Notes:

Name: Date:

Generic: What is this treating?

Dose: Take with Food?

Time: Times per Day: Total Duration:

Other Notes:

COMMUNICATION LOG

To keep track of your conversations with providers, insurance reps, and others.

Date: Time:

Company/Department in call: Name of Rep:

Summary of Call:

Next Steps:

Date: Time:

Company/Department in call: Name of Rep:

Summary of Call:

Next Steps:

Date: Time:

Company/Department in call: Name of Rep:

Summary of Call:

Next Steps:

Date: Time:

Company/Department in call: Name of Rep:

Summary of Call:

Next Steps:

Date: Time:

Company/Department in call: Name of Rep:

Summary of Call:

Next Steps:

Date: Time:

Company/Department in call: Name of Rep:

Summary of Call:

Next Steps:

INSURANCE TRACKER

Insurance Company: Plan Name:

Member ID: Group Number:

Effective Date: Renewal Date:

Annual Deductible: How much has been met?

Out-of-pocket maximum: Customer Service Number:

Primary Care Copay: Specialist Copay: Urgent Care Copay:

Prescription Coverage Info:

Additional Notes:

Insurance Company: Plan Name:

Member ID: Group Number:

Effective Date: Renewal Date:

Annual Deductible: How much has been met?

Out-of-pocket maximum: Customer Service Number:

Primary Care Copay: Specialist Copay: Urgent Care Copay:

Prescription Coverage Info:

Additional Notes:

Insurance Company: Plan Name:

Member ID: Group Number:

Effective Date: Renewal Date:

Annual Deductible: How much has been met?

Out-of-pocket maximum: Customer Service Number:

Primary Care Copay: Specialist Copay: Urgent Care Copay:

Prescription Coverage Info:

Additional Notes:

BILLING TRACKER

Service Provided:

Date of Service:

Provider/Facility:

Amount Billed:

Amount Insurance Covered:

Amount You Paid:

Payment Method & Date:

Additional Notes:

Service Provided:

Date of Service:

Provider/Facility:

Amount Billed:

Amount Insurance Covered:

Amount You Paid:

Payment Method & Date:

Additional Notes:

Service Provided:

Date of Service:

Provider/Facility:

Amount Billed:

Amount Insurance Covered:

Amount You Paid:

Payment Method & Date:

Additional Notes:

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 record and preventative screenings, lifestyle notes (exercise, diet, sleep), personal health goals

VACCINATION RECORDS

Are you up to date on all your vaccinations? ☐ Yes ☐ No

PREVENTATIVE SCREENINGS

What preventative screenings have you received in the last 10 years?

_____ Year _____

_____ Year _____

_____ Year _____

_____ Year _____

LIFESTYLE NOTES

Please list details on your average sleep, exercise, and diet throughout a standard week

PERSONAL HEALTH GOALS

Please list some goals for your health over the next few years

_____

_____

_____

_____

_____

_____