END OF LIFE PLANNER

PERSONAL INFO

PART 1

Personal Details

Name:

Cellphone Number:

DOB: | Age: | Gender:

Citizenship:

Email Address:

License / ID Number:

Social Security Number:

Employment

Employer: | Position:

Start Date: | Phone:

Email:

Street Address:

City: | State: | Zip:

Marital Status

○ Single ○ Married ○ Divorced ○ Separated ○ Widowed

PERSONAL INFO

PART 2

Individual Profile

Nickname:	Blood Type:
Height:	Weight:
Eyes:	Hair:
Identifying Marks:	

Medical Overview

Doctor:		
Street Address:		
City:	State:	Zip:
Phone:	Email:	
Allergies:		
Health Concerns:		
Current Medications:		

Notes

HOME INFO

Details

◯ Monthly Rent ◯ Weekly Rent ◯ Monthly Mortgage ◯ No Costs

Amount:		
Street Address:		
City:	State:	Zip:
Home Phone:		
Entry Code:	Garage Code:	

Occupants

Name	Date of Birth	Relationship

Notes

DOCUMENT LOCATION

Personal Documents	Location
Birth Certificate	
Marriage Certificate	
Passport / ID	
Social Security Card	
Divorce or Separation Papers	
Will and/or Living Trust	
Power of Attorney Documents	
Health Insurance Card	
Academic Transcripts or Diplomas	
Military Records	
Vehicle Registration Documents	
Employment Contracts	
Financial Account Information	
Tax Returns	
Insurance Policies	

DOCUMENT LOCATION

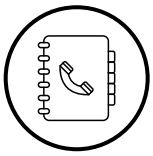
Personal Documents	Location

DOCUMENT LOCATION

Household Documents	Location
Mortgage or Rental Agreements	
Keys	
Property Deeds	
Homeowners Insurance Policy	
Home Warranty Documents	
Home Improvement Receipts	
Home Inventory	
Utilities Bills	
Property Tax Statements	
Maintenance & Repair Records	
Appliance Manuals & Warranties	
Lease Agreements	
Home Security System Information	
Floor Plans and Layouts	
Medication	

DOCUMENT LOCATION

Household Documents	Location



CONTACT DETAILS

EMERGENCY CONTACT LIST

FAMILY MEMBER	FAMILY MEMBER
Name: Address: Phone: Email:	Name: Address: Phone: Email:
FAMILY MEMBER	FAMILY MEMBER
Name: Address: Phone: Email:	Name: Address: Phone: Email:
FRIEND	FRIEND
Name: Address: Phone: Email:	Name: Address: Phone: Email:
HEALTH CARE PROVIDER	HEALTH CARE PROVIDER
Name: Address: Phone: Email:	Name: Address: Phone: Email:
LEGAL REPRESENTATIVE	LEGAL REPRESENTATIVE
Name: Address: Phone: Email:	Name: Address: Phone: Email:

CONTACT IN CASE OF

Illness

Name: Address: Phone: Email:	Name: Address: Phone: Email:

Accident

Name: Address: Phone: Email:	Name: Address: Phone: Email:

Incapacitation

Name: Address: Phone: Email:	Name: Address: Phone: Email:

Death

Name: Address: Phone: Email:	Name: Address: Phone: Email:

HEALTHCARE INFORMATION

FAMILY HISTORY

PART 1

Name:

Disease / Condition	Mother's Side	Father's Side
Heart Disease		
High Blood Pressure		
Stroke		
Arrhythmias		
Congenital Heart Defects		
Cancer:		
Diabetes:		
Alzheimer's Disease		
Parkinson's Disease		
Multiple Sclerosis		
Epilepsy		
Migraine		
Depression		
Bipolar Disorder		
Schizophrenia		
Anxiety Disorders		
Substance Abuse		

FAMILY HISTORY

PART 2

Name:

Disease / Condition	Mother's Side	Father's Side
Asthma		
COPD		
Cystic Fibrosis		
Rheumatoid Arthritis		
Lupus		
Celiac Disease		
Crohn's Disease		
Psoriasis		
Hemophilia		
Thalassemia		
Clotting Disorders		
Chronic Kidney Disease		
Kidney Stones		
Phenylketonuria (PKU)		
Tay-Sachs Disease		
Gaucher's Disease		
Cystinosis		

FAMILY HISTORY

Name:

Disease / Condition	Mother's Side	Father's Side

MEDICAL HISTORY

Personal Details

Name:	
Blood Type:	DOB:
Primary Doctor:	Contact:

Chronic Illnesses / Diseases / Conditions

Allergies

Notes / Medication

Serious Illness / Surgeries / Injuries

Date	Description	Notes	Medication

MEDICAL HISTORY

Name:

Serious Illness / Surgeries / Injuries

Date	Description	Notes	Medication

MEDICAL CONTACT LIST

PRIMARY CARE PHYSICIAN	
Name:	Last Appointment:
Address:	Notes:
Phone:	
Email:	

PEDIATRICIAN	
Name:	Last Appointment:
Address:	Notes:
Phone:	
Email:	

SPECIALIST	
Name:	Last Appointment:
Address:	Notes:
Phone:	
Email:	

DENTIST	
Name:	Last Appointment:
Address:	Notes:
Phone:	
Email:	

THERAPIST	
Name:	Last Appointment:
Address:	Notes:
Phone:	
Email:	

MEDICAL CONTACT LIST

Name:

Address:

Phone:

Email:

Last Appointment:

Notes:

Name:

Address:

Phone:

Email:

Last Appointment:

Notes:

Name:

Address:

Phone:

Email:

Last Appointment:

Notes:

Name:

Address:

Phone:

Email:

Last Appointment:

Notes:

Name:

Address:

Phone:

Email:

Last Appointment:

Notes:

MEDICATION LOG

Personal Details

Name:	Age:	Date:

Medication Details

Medication Name	Dose	Time	M	T	W	T	F	S	S

Instructions / Precautions / Adverse Reactions

ALLERGY TRACKER

Personal Details

Name:	Age:	Date:

Allergy Details

Allergy	Reaction	Medication	Dose

Notes

DOCTOR VISIT TRACKER

Personal Details

Name:	Age:

Doctor Visit Details

Date	Doctor	Visit Description	Medication

Notes

MEDICAL EXPENSE RECORD

Personal Details

Name:

Medical Expense

Date	Description	Billed	Insurance Share	Personal Share	Balance

Notes

IMMUNIZATION RECORD

Personal Details

Name:	Age:

Immunizations

Date	Vaccine Name	Doctor / Clinic	Observations / Reactions

Notes

TEST RESULTS

Personal Details

Name:	Age:

Test Details

Test:	Test:
Date: Doctor / Location: Reason: Results:	Date: Doctor / Location: Reason: Results:
Test:	**Test:**
Date: Doctor / Location: Reason: Results:	Date: Doctor / Location: Reason: Results:
Test:	**Test:**
Date: Doctor / Location: Reason: Results:	Date: Doctor / Location: Reason: Results:
Test:	**Test:**
Date: Doctor / Location: Reason: Results:	Date: Doctor / Location: Reason: Results:

FINANCIAL INFORMATION

BANK ACCOUNT INFO

Bank

Name of Bank:	
Phone:	Email:
Website:	
Street Address:	
City:	State: Zip:
Username:	Password:
Account Type:	Account #:
Account Type:	Account #:
Account Type:	Account #:
Debit Card Info:	
Last 4 Digits:	Expiry:

Notes

CREDIT CARD INFO

Credit Card

Card Name:	Account #:
Rewards:	Interest Rate / Fee:
Payment Address:	
City:	State: Zip:
Website:	
Username:	Password:
Auto Payment: ◯ Yes ◯ No	Due Date:

Credit Card

Card Name:	Account #:
Rewards:	Interest Rate / Fee:
Payment Address:	
City:	State: Zip:
Website:	
Username:	Password:
Auto Payment: ◯ Yes ◯ No	Due Date:

INVESTMENT INFO

Investment Details

Company:	Type of Investment:
Account / Website:	
Account Number:	
Username:	Password:
Current Value:	

Notes

Investment Details

Company:	Type of Investment:
Account / Website:	
Account Number:	
Username:	Password:
Current Value:	

Notes

BILL TRACKER

Month: _____

Bills

Type of Bill	Due Date	Amount	Paid
			◯
			◯
			◯
			◯
			◯
			◯
			◯
			◯
			◯
			◯
			◯
			◯
			◯
			◯
			◯
			◯
			◯
			◯
			◯
			◯

DEBT INFO

Creditors

Creditor:		Creditor:	
Type of Loan:		Type of Loan:	
Interest Rate:	Minimum Payment:	Interest Rate:	Minimum Payment:
Debt Amount:		Debt Amount:	
Date today:		Date today:	
Pay off Debt by:		Pay off Debt by:	
Month 1:	Month 7:	Month 1:	Month 7:
Month 2:	Month 8:	Month 2:	Month 8:
Month 3:	Month 9:	Month 3:	Month 9:
Month 4:	Month 10:	Month 4:	Month 10:
Month 5:	Month 11:	Month 5:	Month 11:
Month 6:	Month 12:	Month 6:	Month 12:

Creditor:		Creditor:	
Type of Loan:		Type of Loan:	
Interest Rate:	Minimum Payment:	Interest Rate:	Minimum Payment:
Debt Amount:		Debt Amount:	
Date today:		Date today:	
Pay off Debt by:		Pay off Debt by:	
Month 1:	Month 7:	Month 1:	Month 7:
Month 2:	Month 8:	Month 2:	Month 8:
Month 3:	Month 9:	Month 3:	Month 9:
Month 4:	Month 10:	Month 4:	Month 10:
Month 5:	Month 11:	Month 5:	Month 11:
Month 6:	Month 12:	Month 6:	Month 12:

RETIREMENT ACCOUNT INFO

Account Details

Company:	Type of Retirement:
Account / Website:	
Account Number:	
Username:	Password:
Current Value:	

Notes

Account Details

Company:	Type of Retirement:
Account / Website:	
Account Number:	
Username:	Password:
Current Value:	

Notes

RETIREMENT TRACKER

Details

Company:	Type of Retirement:

Retirement Funds

Date	Contributions	Balance	Notes

UTILITY TRACKER

Utility Details

Type:	Company:
Account #:	Phone:
Payment Address:	
City:	State: Zip:
Website:	Username:
Password:	Current Amount:
Auto Payment: ◯ Yes ◯ No	Due Date:

Utility Details

Type:	Company:
Account #:	Phone:
Payment Address:	
City:	State: Zip:
Website:	Username:
Password:	Current Amount:
Auto Payment: ◯ Yes ◯ No	Due Date:

ASSET LIST

Asset Details

Asset Type	Description	Value	Insured?
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N

INSURANCE INFORMATION

HOME INSURANCE

Details

Property Address:		
City:	State:	Zip:
Agent Name:	Phone:	
Email:	Start Date:	
Company:	Policy #:	
To make a claim:		
Notes:		

Details

Property Address:		
City:	State:	Zip:
Agent Name:	Phone:	
Email:	Start Date:	
Company:	Policy #:	
To make a claim:		
Notes:		

CAR INSURANCE

Details

Make:	Model:
Year:	VIN:
Agent Name:	Phone:
Email:	Start Date:
Company:	Policy #:
To make a claim:	
Notes:	

Details

Make:	Model:
Year:	VIN:
Agent Name:	Phone:
Email:	Start Date:
Company:	Policy #:
To make a claim:	
Notes:	

HEALTH INSURANCE

Details

Insured Person:		
Company:	Address:	
City:	State:	Zip:
Agent Name:	Phone:	
Email:	Start Date:	
Policy #:		
Health Coverage:		
Dental Coverage:		
Vision Coverage:		
RX:	Deductible:	
Notes:		

LIFE INSURANCE

Details

Insured Person:	
Beneficiary:	
Benefit:	
Company:	Policy #:
Address:	
City:	State: Zip:
Agent Name:	Phone:
Email:	Start Date:
Notes:	

OTHER INSURANCE

Details

Insurance Type:	
Company:	Policy #:
Agent Name:	Phone:
Email:	Start Date:
RX:	Deductible:
To make a claim:	
Notes:	

Details

Insurance Type:	
Company:	Policy #:
Agent Name:	Phone:
Email:	Start Date:
RX:	Deductible:
To make a claim:	
Notes:	

DIGITAL FOOTPRINT

PASSWORD TRACKER

Online

Website:	Notes:
Username:	
Email:	
Password:	

Website:	Notes:
Username:	
Email:	
Password:	

Website:	Notes:
Username:	
Email:	
Password:	

Website:	Notes:
Username:	
Email:	
Password:	

Website:	Notes:
Username:	
Email:	
Password:	

SECURITY Q&A

Question	Answer

SUBSCRIPTION TRACKER

Subscriptions

Subscription:	Amount:
Login Details:	Monthly / Yearly:
Password:	Renewal Date:
Email:	Keep / Cancel:

Subscription:	Amount:
Login Details:	Monthly / Yearly:
Password:	Renewal Date:
Email:	Keep / Cancel:

Subscription:	Amount:
Login Details:	Monthly / Yearly:
Password:	Renewal Date:
Email:	Keep / Cancel:

Subscription:	Amount:
Login Details:	Monthly / Yearly:
Password:	Renewal Date:
Email:	Keep / Cancel:

Subscription:	Amount:
Login Details:	Monthly / Yearly:
Password:	Renewal Date:
Email:	Keep / Cancel:

E-DEVICES DETAILS

Login Details

E-Device:

Username (if applicable):

Password:

Email used:

E-Device:

Username (if applicable):

Password:

Email used:

E-Device:

Username (if applicable):

Password:

Email used:

E-Device:

Username (if applicable):

Password:

Email used:

E-Device:

Username (if applicable):

Password:

Email used:

SOCIAL MEDIA PROFILES

Login Details

Platform / Website:

Username (if applicable):

Password:

Email used:

Platform / Website:

Username (if applicable):

Password:

Email used:

Platform / Website:

Username (if applicable):

Password:

Email used:

Platform / Website:

Username (if applicable):

Password:

Email used:

Platform / Website:

Username (if applicable):

Password:

Email used:

EMAIL ACCOUNTS

Login Details

Platform / Website:

Email Address:

Password:

Notes:

Platform / Website:

Email Address:

Password:

Notes:

Platform / Website:

Email Address:

Password:

Notes:

Platform / Website:

Email Address:

Password:

Notes:

Platform / Website:

Email Address:

Password:

Notes:

Platform / Website:

Email Address:

Password:

Notes:

FINAL PREPARATIONS

END OF LIFE DIRECTIVES PART 1

Last Will & Testament

Location of Document:		
Executor:	Phone:	
Prepared by:	Phone:	
Address:		
City:	State:	Zip:
Notes:		

Trust Agreement

Location of Document:		
Trustee:	Phone:	
Prepared by:	Phone:	
Address:		
City:	State:	Zip:
Notes:		

END OF LIFE DIRECTIVES PART 2

Healthcare Power of Attorney

Location of Document:		
Person named:	Phone:	
Prepared by:	Phone:	
Address:		
City:	State:	Zip:
Notes:		

Financial Power of Attorney

Location of Document:		
Person named:	Phone:	
Prepared by:	Phone:	
Address:		
City:	State:	Zip:
Notes:		

ORGAN DONATION

Details

Name:		
Address:		
City:	State:	Zip:

Organ Donation Intentions

I hereby express my intention to be an organ donor, and I wish to donate my organs for transplantation purposes. I understand that specific medical and legal requirements must be met for the donation to occur.

Organ Donation Organizations

I would like to donate my organs to the following organizations or programs:

Restrictions or Limitations

I have the following restrictions or limitations on my organ donation:

Communication and Authorization

I request that my family or designated healthcare agent be involved in the organ donation process and informed of my decision. I understand that their involvement is important for facilitating the donation.

I hereby authorize the necessary medical procedures and tests required for organ donation, as permitted by local laws and regulations.

Witnesses

Name: _____ Signature: _____ Date: _____

Witness 1: _____ Signature: _____ Date: _____

Witness 2: _____ Signature: _____ Date: _____

By completing and signing this organ donation sheet, I declare my intentions and preferences regarding organ donation. I understand the importance of complying with legal and regulatory requirements, and I encourage my loved ones and healthcare providers to honor and respect my decision.

FUNERAL ARRANGEMENTS

Preferred Funeral Home

Funeral Home Name:

Contact: | Phone:

Address:

City: | State: | Zip:

Funeral Expenses

Prepaid funeral expenses? ☐ Yes ☐ No ☐ Partial

Amount prepaid: | Total Amount:

Funeral Policy #: | Company:

Funeral Service Preferences

Religious Affiliation:

Service performed by: | Type of Service:

Flowers: | Music:

Notes:

Burial / Cremation

☐ Burial ☐ Cremation

Notes:

OBITUARY INFO

Personal Information

Legal Name:	Maiden Name:
DOB:	State / Country of Birth:

Survived by

Spouse:

Children:

Grandchildren:

Pets:

Achievements

Affiliations

Notes