MEDICAL BINDER

Courtesy of Elite Family Office

Adil H. Chagani, Director
Elite Family Office
Tel: (604) 889-8228
Web: www.elitefamilyoffice.ca

MEDICAL *Contacts*

NAME:
ADDRESS:
PHONE:
EMAIL:
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DOCTOR *Visits*

DATE; **DOCTOR:** **REASON FOR VISIT:**

VITAL STATS	TESTS	RESULTS	TREATMENT
HEIGHT			
WEIGHT			
BP			

DATE; **DOCTOR:** **REASON FOR VISIT:**

VITAL STATS	TESTS	RESULTS	TREATMENT
HEIGHT			
WEIGHT			
BP			

DATE; **DOCTOR:** **REASON FOR VISIT:**

VITAL STATS	TESTS	RESULTS	TREATMENT
HEIGHT			
WEIGHT			
BP			

MEDICATION *Log*

Date _____

NAME:
MEDICATION:
DOSE/DIRECTIONS:
DATE STARTED/ENDED:
PURPOSE:
PRESCRIBED BY:
NOTES & COMMENTS

BLOOD SUGAR *Tracker*

	MEALS	1 HR	2 HR	3 HR
SUNDAY	B:			
	L:			
	D:			
	NOTES:			
MONDAY	B:			
	L:			
	D:			
	NOTES:			
TUESDAY	B:			
	L:			
	D:			
	NOTES:			
WEDNESDAY	B:			
	L:			
	D:			
	NOTES:			
THURSDAY	B:			
	L:			
	D:			
	NOTES:			

BLOOD SUGAR *Tracker*

	MEALS	1 HR	2 HR	3 HR
FRIDAY	B:			
	L:			
	D:			
	NOTES:			
SATURDAY	B:			
	L:			
	D:			
	NOTES:			

NOTES

SYMPTOMS *Tracker*

DATE	DURATION	FOOD/MEDICATION/ ACTIVITY	SYMPTOM

DENTAL *Log*

DATE	DENTIST	TREATMENT	FOLLOW-UP

SURGERIES & Procedures

DATE	SURGERY/ PROCEDURE	PHYSICIAN/ HOSPITAL	FOLLOW-UP

GROWTH *Tracker*

CHILD'S NAME:	
DATE OF BIRTH:	
WEIGHT AT BIRTH:	
HEIGHT AT BIRTH:	

DATE	AGE	HEIGHT	WEIGHT	NOTES

BLOOD PRESSURE *Log*

DATE	TIME	BLOOD PRESSURE	PULSE	NOTES

UPCOMING *Appointments*

DATE	TIME	DOCTOR	REASON	LOCATION

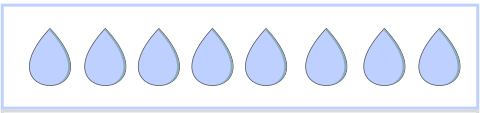
LAB Tracker

DATE	LAB TEST	LAB LOCATION	REQUESTING DOCTOR	NOTES

MEDICAL *Expenses*

DATE	DESCRIPTION	DOCTOR	COST	INSURED

WATER *Tracker*

1		17	
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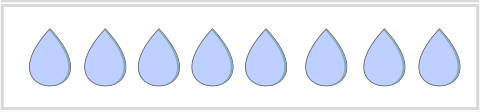
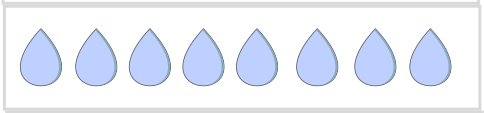
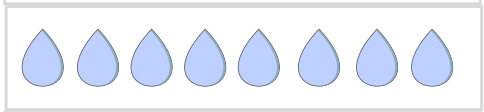
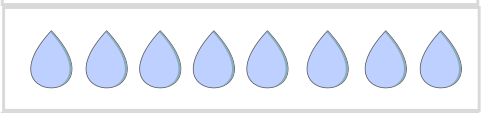
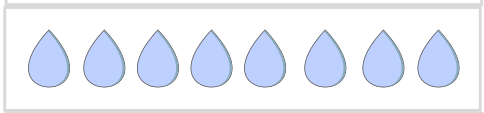
3		19	
4		20	
5		21	
6		22	
7		23	
8		24	
9		25	
10		26	
11		27	
12		28	
13		29	
14		30	
15		31	
16			

SELF CARE *Tracker*

MY GOALS:

- _____
- _____
- _____

B	L	D

MORNING ROUTINE	EVENING ROUTINE

SLEEP TRACKER

WATER TRACKER

MOOD TRACKER

EXERCISE TRACKER

READING TRACKER

REWARDS TRACKER

NOTES & DOODLES

FAMILY *History*

MOTHER'S SIDE:

NAME	RELATION-SHIP	CONDITION/ ILLNESS	CAUSE OF DEATH	AGE OF ONSET

FATHER'S SIDE:

NAME	RELATION-SHIP	CONDITION/ ILLNESS	CAUSE OF DEATH	AGE OF ONSET

MEDICAL *Release*

EMERGENCY CONTACT INFORMATION

(a new form must be signed every year) **YEAR** _____

CHILD'S NAME: **DATE OF BIRTH:**

PARENTS OR GUARDIAN

- **NAME:**
- **RELATIONSHIP:**
- **CELL PHONE:**
- **WORK PHONE:**
- **WORK ADDRESS:**

- **NAME:**
- **RELATIONSHIP:**
- **CELL PHONE:**
- **WORK PHONE:**
- **WORK ADDRESS:**

OTHER CONTACTS IF PARENTS CANNOT BE REACHED

- **NAME:**
- **RELATIONSHIP:**
- **CELL PHONE:**

- **NAME:**
- **RELATIONSHIP:**
- **CELL PHONE:**

NAMES OF PERSON/S AUTHORIZED TO PICK CHILD UP

MEDICATIONS: ALLERGIES: DOCTOR INFO:

_____ _____ _____

_____ _____ _____

_____ _____ _____

LIFE THREATENING?
YES NO

I grant authorization and consent for _____to administer first aid treatment for minor injuries on my child _____. If emergency, I grant my authorization to summon any and all professional personnel to attend and treat the minor while in their care.

SIGNATURE _____ **DATE** _____

Notes

HOSPITALIZATIONS *& ER*

VITAL HISTORY

DATE: **LOCATION:**

PHYSICIAN SEEN:

REASON:

DIAGNOSIS:

TREATMENT:

ADMITTED TO HOSPITAL: **DISCHARGED:**

NOTES:

VITAL HISTORY

DATE: **LOCATION:**

PHYSICIAN SEEN:

REASON:

DIAGNOSIS:

TREATMENT:

ADMITTED TO HOSPITAL: **DISCHARGED:**

NOTES:

IMMUNIZATION *Record*

CHILD NAME:

VACCINATION: **DATE:**

FACILITY: **AGE:**

BODY SITE: **NEXT DUE DATE:**

CHILD NAME:

VACCINATION: **DATE:**

FACILITY: **AGE:**

BODY SITE: **NEXT DUE DATE:**

CHILD NAME:

VACCINATION: **DATE:**

FACILITY: **AGE:**

BODY SITE: **NEXT DUE DATE:**

CHILD NAME:

VACCINATION: **DATE:**

FACILITY: **AGE:**

BODY SITE: **NEXT DUE DATE:**

YEARLY *Doctor Visits*

YEARLY CHECKUP

DATE: **PHYSICIAN:**

CLINIC: **PHONE:**

ADDRESS: **DATE OF LAST CHECKUP:**

RESULTS:

NEXT CHECKUP:

REMINDER IN CALENDAR:

ISSUES/CONCERNS:

YEARLY CHECKUP

DATE: **PHYSICIAN:**

CLINIC: **PHONE:**

ADDRESS: **DATE OF LAST CHECKUP:**

RESULTS:

NEXT CHECKUP:

REMINDER IN CALENDAR:

ISSUES/CONCERNS:

LAB *Test Results*

DATE	LAB LOCATION	REQUESTING DOCTOR
LAB/S:		
RESULTS:		
COMMENTS:		

DATE	LAB LOCATION	REQUESTING DOCTOR
LAB/S:		
RESULTS:		
COMMENTS:		

DATE	LAB LOCATION	REQUESTING DOCTOR
LAB/S:		
RESULTS:		
COMMENTS:		

HEALTH *Overview*

PERSONAL INFORMATION	
D.O,B.:	BIRTH PLACE:
WEIGHT:	EYE COLOR:
HEIGHT:	GLASSES/CONTACTS:
BLOOD TYPE:	BIRTHMARK/SCARS:

MEDICAL CONDITIONS		
CONDITION	DATE	TREATING

FOOD, DRUG, & OTHER ALLERGIES		
ALLERGY	TREATMENTS	DOSE

MEDICATIONS/SUPPLEMENTS		
MEDICATIONS	TAKEN FOR	DOSE

VISION *Exams*

OPTOMETRIST OFFICE	
OPTOMETRIST:	FACILITY:
ADDRESS:	PHONE:
ACCOUNT#:	WEBSITE:

DATE	OPTOMESTRIST	TREATMENT	NOTES

MEDICAL *Conditions*

DIAGNOSIS:	
DATE OF DIAGNOSIS:	FACILITY:
DOCTOR:	PHONE:
ACCOUNT#:	WEBSITE:

SYMPTOMS	FREQUENCY	NOTES
TREATMENT PLAN	**MEDICATIONS**	**NOTES**
DATE	**PROCEDURE/ SURGERY**	**NOTES**

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