

— Mini Medical —

EMERGENCY

— Information Binder —



Helping you organize your health records

If you enjoyed this content, be sure to order Lisa's book *The Paper Solution*.
Order now at organize365.com.



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



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: _____

IDS

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: _____

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: _____

IDS

E-mail: _____
 Driver's License #: _____ State: _____
 Passport #: _____ Passport location: _____
 Father's Full Name: _____ Birthdate: _____
 Mother's Full Name: _____ Birthdate: _____

IMPORTANT PEOPLE

Doctor: _____ Phone: _____
 Dentist: _____ Phone: _____
 Eye Doctor: _____ Phone: _____
 Other Medical Team: _____

EDUCATION

Pharmacy: _____ Phone: _____
 Preferred Hospital: _____ Phone: _____
 Primary School Name: _____ Years: _____
 Address: _____ Phone: _____
 Middle School Name: _____ Years: _____
 Address: _____ Phone: _____
 High School Name: _____ Years: _____
 Address: _____ Phone: _____

HEALTH INSURANCE INFORMATION

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MEDICARE PRIMARY INSURANCE

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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.

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

- _____
- _____
- _____
- _____
- _____

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:

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)

