

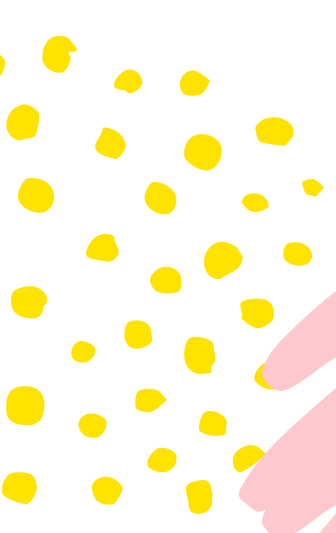


ENDOMETRIOSIS FOUNDATION OF HOUSTON



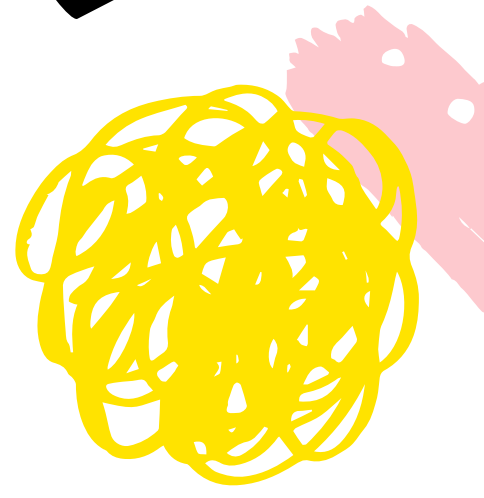
Endometriosis Medical Records & Planner





This planner belongs to:

[Blank white box for name]



VITAL INFORMATION

Personal Patient Information

INSURANCE INFORMATION

Insurance Contact and Policy Information

PHARMACY INFORMATION

Pharmacy Contact Information

MEDICAL CONTACTS

Doctor Information and Portal Accounts

PROCEDURES/TREATMENTS/SURGERIES

Detailed Patient History

BLOODWORK/LABS/SCANS

Tests and Result

MEDICINE/SUPPLEMENT/VITAMIN LIST

Current Drug List

APPOINTMENT CALENDAR/PERIOD TRACKER

Calendar and Period Trends

SYMPTOM/PAIN TRACKER

Symptom and Pain Trends

DIET/WATER LOG

Food Sensitivities and Water Intake

EXCISION SURGERY APPOINTMENT

QUESTIONS & NOTES

Comprehensive question list for vetting your doctor

CAREGIVER/FRIENDO LIST

Go to list for help

HOSPITAL INFORMATION

instructions for day of surgery

PRE/POST SURGICAL CHECKLIST AND TIPS

Shopping/Task Lists for planning your surgical care

MEDICAL EXPENSES & PAYMENT TRACKER

Running record of expenses for taxes

MEDICAL RECEIPTS

Receipts (appointments, surgeries, prescription/ over the counter medication, medical supplies/equipment etc.)

TABLE CONTENTS

ENDOMETRIOSIS GLOSSARY

Endometriosis terminology

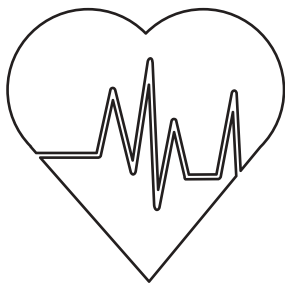
RESOURCES

A compilation of useful resources

WAITING ROOM RELAXATION

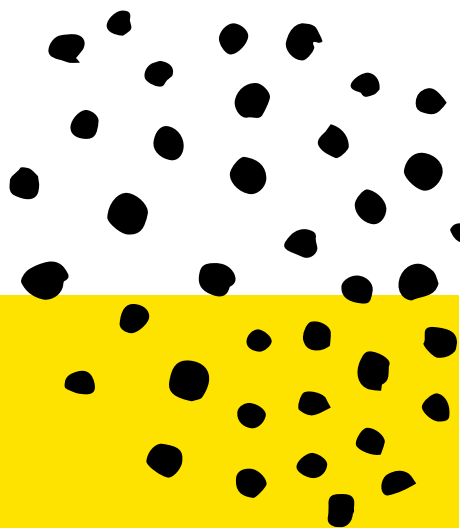
TABLE

CONTENTS

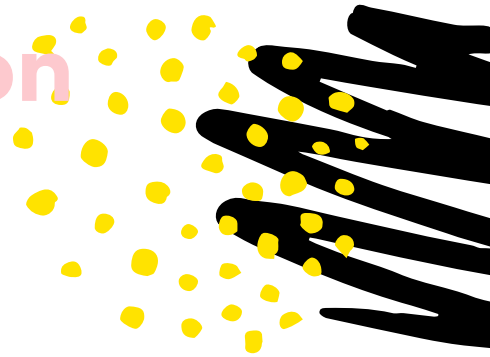
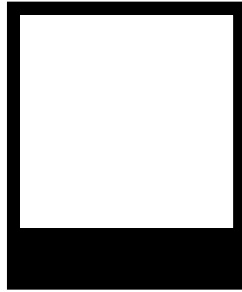


Vital Information

PATIENT INFORMATION



Vital Information



Name: _____

Birthday: _____ / _____ / _____

Age: _____ Height _____ ' _____ " Weight _____

If minor, name of parent/guardian: _____

Address: _____

Phone Number (Home) _____ Cell _____

Email address: _____ @ _____

Blood Type: _____

Allergies: _____

Identifying Markers (medical tattoos/piercings/alert bracelets or necklaces etc) _____

Medical Conditions: _____

Current Medications: _____

Emergency Contact:

Name: _____

Relationship to patient _____

Address: _____

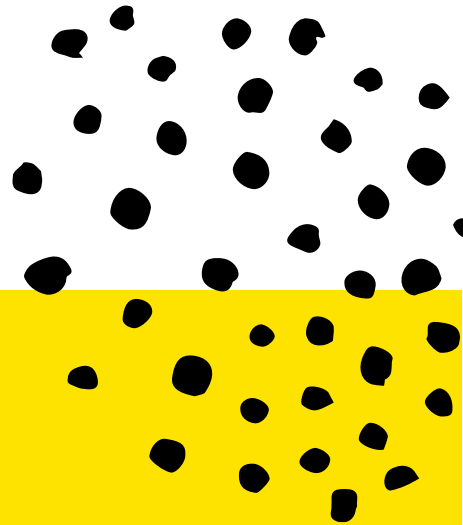
Phone Number (Home) _____ Cell _____

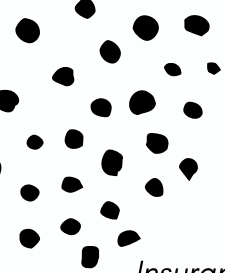
Email address: _____ @ _____



Insurance Information

*INSURANCE CONTACT &
POLICY INFORMATION*





Insurance Type: _____

Provider Name: _____

Group Number: _____ Policy Number: _____

ID Number _____

Contact/Agent: _____

Customer Service Number _____

Address: _____

Website: _____

Insurance Type: _____

Provider Name: _____

Group Number: _____ Policy Number: _____

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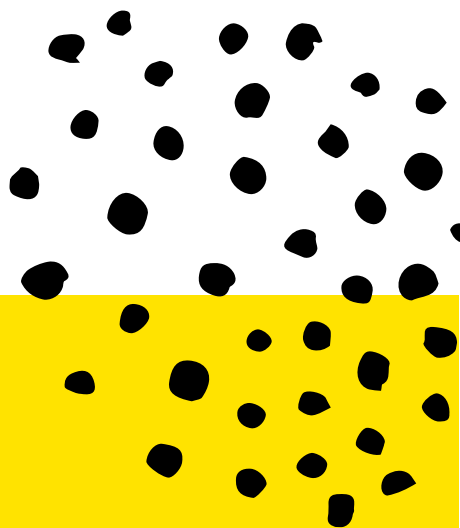


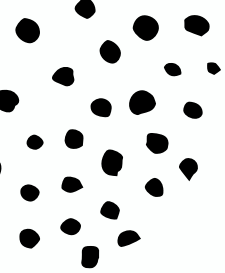
Insurance
Information



Medical Contacts

*DOCTOR INFORMATION &
PORTAL ACCOUNTS*





Doctor Contact Information

Name: _____

Specialty: _____

Address: _____

City/State/Zip Code _____

Phone Number: _____

Fax: _____

Website: _____

Portal: _____

Username: _____

Password: _____

Name: _____

Specialty: _____

Address: _____

City/State/Zip Code _____

Phone Number: _____

Fax: _____

Website: _____

Portal: _____

Username: _____

Password: _____

Name: _____

Specialty: _____

Address: _____

City/State/Zip Code _____

Phone Number: _____

Fax: _____

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Name: _____

Specialty: _____

Address: _____

City/State/Zip Code _____

Phone Number: _____

Fax: _____

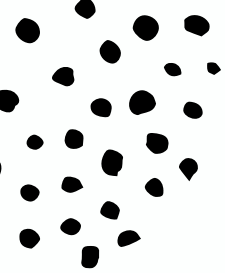
Website: _____

Portal: _____

Username: _____

Password: _____





Doctor Contact Information

Name: _____

Specialty: _____

Address: _____

City/State/Zip Code _____

Phone Number: _____

Fax: _____

Website: _____

Portal: _____

Username: _____

Password: _____

Name: _____

Specialty: _____

Address: _____

City/State/Zip Code _____

Phone Number: _____

Fax: _____

Website: _____

Portal: _____

Username: _____

Password: _____

Name: _____

Specialty: _____

Address: _____

City/State/Zip Code _____

Phone Number: _____

Fax: _____

Website: _____

Portal: _____

Username: _____

Password: _____

Name: _____

Specialty: _____

Address: _____

City/State/Zip Code _____

Phone Number: _____

Fax: _____

Website: _____

Portal: _____

Username: _____

Password: _____

