Live a simpler, safer, less cluttered life

# Tracking medication and medical paperwork

Maria Spetalnik
Mail@MariaSpetalnik.com

Pills, appointments, remembering everything you wanted to ask the doctor, payments due…


MON
TUE
WED
THU
FRI
SAT
SUN


2 pack
Su
M
T
W
Th
F
Sa


MON
Backup
MON
Night
MON
Noon
MON
Morn
TUE
Backup
TUE
Night
TUE
WED
Backup
WED
Night


START
OFF


6:00 PM
Saturday
1 ATORVASTATIN 20 MG
1 METFORMIN 1000 MG
1 METOPROLOL ER 50 M
1 OXYBUTYNIN 5 MG
amazon pharmacy
12:00
Saturday
1 LANSOPRAZ
1 OXYBUTYNI 5
1 ASPIRIN 81 MG
amazon pharmacy
8:00 AM
Saturday
Oct 5
1 LEVOTHYROXINE 137 MCG
1 METOPROLOL ER 50 MG
1 OXYBUTYNIN 5 MG
1 VITAMIN D3 2000 IU
amazon pharmacy

| | Day 1 | Day 2 | Day 3 | Day 4 | Day 5 | Day 6 | Day 7 |
|---|---|---|---|---|---|---|---|
| | 1/30 | 1/31 | 2/1 | 2/2 | 2/3 | 2/4 | 2/5 |
| **MORNING** | | | | | | | |
| Alloporinal - 2tabs | | | | | | | |
| Alloporinal - 1 tab | | | | | | | |
| Ordanston | | | | as needed for nausea | | | |
| Zyrtec | | | | | | | |
| Multivitamin | | | | | | | |
| D3 | | | | | | | |
| Lisinopril | | | | | | | |
| Prednisone | | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **EVENING** | | | | | | | |
| Ordanston | | | | | | | |
| Simvistatin | | | | | | | |
| CoQ10 | | | | | | | |
| Claritin | | | | | | as needed for pain | |
| Injection | | | | | | | |
| | | | | | | | |
| **As Needed** | | | | | | | |
| Tylenol | max dose 3000 mg/day | | | | | | |
| Imodium | as needed 4 Diarrehea | | | | | | |
| Senokot or Dulcolax | for constipation | | | | | | |
| | | | | | | | |
| **NO NSAIDS** | | | | | | | |

# Appointment Tracker

Your Name

Date_9/3/26___ Doctor:_Katz_____

Reason for visit:

Physical_____

_____

Concerns to bring up:

_____

_____

_____

# Appointment Tracker - continued

Instructions given:

_____

_____

_____

Medications / Tests ordered:

_____

_____

_____

When should follow up be done:

_____

# Medical Payment Tracker – Part 1

| Date of service | Office | Account # | Invoice # | Service |
|---|---|---|---|---|
| | | | | |
| 1/26/2026 | Smith and Associates | 156438 | 84561 | Physical |
| | | | | Follow-up |
| | | | | Blood Test |

# Medical Payment Tracker – Part 2

| Doctor | Co-pay paid at visit | Insurance payment | Insurance payment date | Balance payment | Balance paid date | Check # |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| Katz | 40 | 296.42 | 6/15/2026 | 32.48 | 7/30/2026 | 645 |

# My Personal Health Record

(703) 574-1113 or (855) 284-3246
Mail@ConquerTheClutter.org

## To better manage my health and medications, I can...

- ☑ Take this Personal Health Record with me wherever I go, including all doctor visits and future hospitalizations.
- ☑ Call my doctor when I have questions about my medications, or if I would like to change how I take my medications.
- ☑ Inform my doctors of **ALL** medications that I take, including over-the-counter drugs, vitamins, supplements and herbal formulas.
- ☑ Update my Medication Record with any changes to my medications.

- [ ] Know why I am taking each of my medications
- [ ] Know how much, time of day, and length of time I am taking **or have taken** each medication.
- [ ] Consider using a weekly or monthly medication (pill) organizer.
- [ ] Know possible medication side effects to watch out for and what to do if I notice any.

## Personal Information

Name: _____

Address: _____

City, State, Zip: _____

Home Telephone: _____

Mobile/Work Telephone: _____

## Emergency Contact

Name: _____

Relation to Patient: _____

Home Telephone: _____

Mobile/Work Telephone: _____

## Caregiver Information

Name: _____

Relation to Patient: _____

Home Telephone: _____

Mobile/Work Telephone: _____

## Provider Information

Primary Care Doctor: _____

Telephone: _____

Other Providers: _____

Telephone: _____

Other Providers: _____

Telephone: _____

Home Care Agency: _____

Telephone: _____

Pharmacy: _____

Telephone: _____

Primary Insurance Provider

Telephone: _____

Subscriber ID: _____ Group #: _____

Supplemental Insurance Provider

Telephone: _____

Subscriber ID: _____ Group #: _____

## My Personal Goals

What would I like to do or accomplish over the next week, month, and year? List any health, activity, and life goals.

## What Do I Need to Do to Reach My Goals?

## Red Flags

These are symptoms and drug reactions I need to be able to recognize and know how to handle if they occur.

| | |
|---|---|
| | |
| | |
| | |
| | |

# Medical History

Indicate whether you currently experience or have a history of the following medical problems.

- ☐ Cancer
  - Type _____
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ Congestive Heart Failure
- ☐ Stroke
- ☐ Kidney Disease
- ☐ High Cholesterol
- ☐ Thyroid Problem
- ☐ COPD
- ☐ Bleeding Disorder
- ☐ Seizures
- ☐ Heart Attack
- ☐ Diabetes
  - Type _____
- ☐ Glaucoma
- ☐ Dementia/Alzheimer's
- ☐ Anxiety
  - ☐ Former
  - ☐ Current
- ☐ Depression
  - ☐ Former
  - ☐ Current

Other: _____

_____

_____

_____

_____

_____

_____

_____

Indicate whether you have had the following immunizations.

- ☐ Tetanus, diphtheria pertussis (Tdap) vaccine
- ☐ Pneumococcal vaccine
- ☐ Shingles vaccine
- ☐ Influenza (flu) vaccine

## Recent Hospitalization/Surgery/ER Visits

Date admitted: _____ Date discharged: _____

Hospital: _____

Reason for hospitalization: _____

Date admitted: _____ Date discharged: _____

Hospital: _____

Reason for hospitalization: _____

Date admitted: _____ Date discharged: _____

Hospital: _____

Reason for hospitalization: _____

## My Questions for My Doctor

Remember to discuss medication questions with your doctor.

## My Primary Health Concerns

# ☑ My Discharge Checklist

Before I leave each facility, the following tasks should be completed:

| | |
|---|---|
| | I have been involved in decisions about what will take place after I leave the facility. |
| | I understand where I am going after I leave this facility and what will happen with me once I arrive. |
| | I have the name and telephone number of a person I should contact if a problem arises during my transfer. |
| | I understand what my medications are, how to obtain them, and how to take them. |

| | |
|---|---|
| | I understand the potential side effects of each medication and whom I should call if I experience any side effects. |
| | I understand what symptoms I need to watch for and whom I should call when I notice them. |
| | I understand how to keep my health problems from intensifying. |
| | My doctor and nurse **have** answered my most important questions priot to leaving the care facility. |
| | I have scheduled any necessary follow-up appointments with my doctor. |
| | I have transportation to and from this appointment. |

## Advance Care Directive

Advance Care Directives are written instructions for your family and medical providers about the kind of medical treatment you would want if you became unable to give instructions. An advance directive can also specify one or more persons to make medical decisions for you in the event that you are unable to do so for yourself.

**Do you have an advance care directive:** ☐ Yes ☐ No

☐ Living Will ☐ Five Wishes ☐ CPR Directive

☐ Resuscitate ☐ Do Not Resuscitate

☐ Medical Power of Attorney: Name/Telephone:

_____

Location of the document(s)

_____

**Provide a copy of your advance care directive to your doctor.**

# Medications and Supplements Record


## In the morning, I take...

| **Drug name** | **It looks like..**<br>Color, shape, imprint, etc. | **How Many?**<br># of pills | **How do I take it?**<br>with food, water, etc. | **Start**<br>Date | **Stop**<br>Date | **Doctor Name** |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

# Medications and Supplements Record

## In the afternoon, I take...

| **Drug name** | **It looks like..** Color, shape, imprint, etc. | **How Many?** # of pills | **How do I take it?** with food, water, etc. | **Start** Date | **Stop** Date | **Doctor Name** |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

# Medications and Supplements Record

## In the evening, I take...

| **Drug name** | **It looks like..** Color, shape, imprint, etc. | **How Many?** # of pills | **How do I take it?** with food, water, etc. | **Start** Date | **Stop** Date | **Doctor Name** |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

# Medications and Supplements Record

## Before I go to bed, I take...

| **Drug name** | **It looks like..** Color, shape, imprint, etc. | **How Many?** # of pills | **How do I take it?** with food, water, etc. | **Start** Date | **Stop** Date | **Doctor Name** |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |