Table of Contents

Your medicines, doses, and why you take them **2–3**

Schedule of Doctors Appointments **4–5**

Immunizations **6**

Patient Record of Vitals **7–8**

Surgeries & Procedures **9**

Cholesterol Check **10**

Blood Glucose Tracking **11–14**

Patient Scorecard **15–26**

Notes **27**

Statement of Nondiscrimination **28**

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Your medicines, doses, and why you take them

Medication	Dose	Frequency	Purpose

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Your medicines, doses, and why you take them

Medication	Dose	Frequency	Purpose

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Schedule of Doctors Appointments

Doctor's Name	Date	Time	Concerns

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Schedule of Doctors Appointments

Doctor's Name	Date	Time	Concerns

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Adult Immunization Record

Always carry this record with you and have your health professional or clinic keep it up to date.

	Type of Vaccine	Date Given mo/day/yr	Location	Date Next Dose Due
Pneumococcal				
Influenza				
MMR		1		
		2		
Varicella		1		
		2		
Zoster		1		
Td Tdap				
Hep B		1		
		2		
		3		
Hep A		1		
		2		
COVID-19		1		
		2		

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Patient Record of Vitals

Date	Weight	Pulse	O^2 Level	Blood Pressure Systolic / Diastolic
				/
				/
				/
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Patient Record of Vitals

Date	Weight	Pulse	O^2 Level	Blood Pressure Systolic / Diastolic
				/
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Surgeries & Procedures

Date	Procedure	Physician

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Cholesterol Check

Date	Total Cholesterol	HDL	LDL	Triglycerides

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Blood Glucose Tracking

My target blood glucose ranges are _______ mg/dl to _______ mg/dl before meals and less than _______ mg/dl after meals.

MONTH ________			BLOOD GLUCOSE (mmol/L)									INSULIN (Units)				
Date			Breakfast		Lunch		Dinner		Bedtime			Breakfast	Lunch	Dinner	Bedtime	Ketones (+ or -)
			before	after	before	after	before	after	before	after						
	MON	TIME									TIME					
		RESULTS									UNITS					
	TUES	TIME									TIME					
		RESULTS									UNITS					
	WED	TIME									TIME					
		RESULTS									UNITS					
	THUR	TIME									TIME					
		RESULTS									UNITS					
	FRI	TIME									TIME					
		RESULTS									UNITS					
	SAT	TIME									TIME					
		RESULTS									UNITS					
	SUN	TIME									TIME					
		RESULTS									UNITS					

Weight this week:

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Blood Glucose Tracking

My target blood glucose ranges are _______ mg/dl to _______ mg/dl before meals and less than _______ mg/dl after meals.

MONTH ________			BLOOD GLUCOSE (mmol/L)									INSULIN (Units)				
Date			Breakfast		Lunch		Dinner		Bedtime			Breakfast	Lunch	Dinner	Bedtime	Ketones (+ or -)
			before	after	before	after	before	after	before	after						
	MON	TIME									TIME					
		RESULTS									UNITS					
	TUES	TIME									TIME					
		RESULTS									UNITS					
	WED	TIME									TIME					
		RESULTS									UNITS					
	THUR	TIME									TIME					
		RESULTS									UNITS					
	FRI	TIME									TIME					
		RESULTS									UNITS					
	SAT	TIME									TIME					
		RESULTS									UNITS					
	SUN	TIME									TIME					
		RESULTS									UNITS					

Weight this week:

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Blood Glucose Tracking

My target blood glucose ranges are _______ mg/dl to _______ mg/dl before meals and less than _______ mg/dl after meals.

MONTH ________			BLOOD GLUCOSE (mmol/L)									INSULIN (Units)				
Date			Breakfast		Lunch		Dinner		Bedtime			Breakfast	Lunch	Dinner	Bedtime	Ketones (+ or -)
			before	after	before	after	before	after	before	after						
	MON	TIME									TIME					
		RESULTS									UNITS					
	TUES	TIME									TIME					
		RESULTS									UNITS					
	WED	TIME									TIME					
		RESULTS									UNITS					
	THUR	TIME									TIME					
		RESULTS									UNITS					
	FRI	TIME									TIME					
		RESULTS									UNITS					
	SAT	TIME									TIME					
		RESULTS									UNITS					
	SUN	TIME									TIME					
		RESULTS									UNITS					

Weight this week:

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Blood Glucose Tracking

My target blood glucose ranges are ______ mg/dl to ______ mg/dl before meals and less than ______ mg/dl after meals.

MONTH ______			BLOOD GLUCOSE (mmol/L)									INSULIN (Units)				
Date			Breakfast		Lunch		Dinner		Bedtime			Breakfast	Lunch	Dinner	Bedtime	Ketones (+ or -)
			before	after	before	after	before	after	before	after						
	MON	TIME									TIME					
		RESULTS									UNITS					
	TUES	TIME									TIME					
		RESULTS									UNITS					
	WED	TIME									TIME					
		RESULTS									UNITS					
	THUR	TIME									TIME					
		RESULTS									UNITS					
	FRI	TIME									TIME					
		RESULTS									UNITS					
	SAT	TIME									TIME					
		RESULTS									UNITS					
	SUN	TIME									TIME					
		RESULTS									UNITS					

Weight this week:

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Patient Scorecard

Your Agency Name

Name:____________________ Beginning Date:____________________

Attending Nurse:____________________

Attending Physician:____________________

Date	Weight	Fatigue	Short of Breath or Cough?	Foot or Ankle Swelling?	Difficulty Sleeping?	Activity Level?	Temp	Pulse	B/P	Resp.

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Patient Scorecard

Your Agency Name

Date	Weight	Fatigue	Short of Breath or Cough?	Foot or Ankle Swelling?	Difficulty Sleeping?	Activity Level?	Temp	Pulse	B/P	Resp.

Completion Date:____________________________

Patient Signature:____

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Patient Scorecard

Your Agency Name

Name:______________________ Beginning Date:______________________

Attending Nurse:______________________

Attending Physician:______________________

Date	Weight	Fatigue	Short of Breath or Cough?	Foot or Ankle Swelling?	Difficulty Sleeping?	Activity Level?	Temp	Pulse	B/P	Resp.

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Patient Scorecard

Your Agency Name

Date	Weight	Fatigue	Short of Breath or Cough?	Foot or Ankle Swelling?	Difficulty Sleeping?	Activity Level?	Temp	Pulse	B/P	Resp.

Completion Date:________________________________

Patient Signature:________________________________

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Patient Scorecard

Your Agency Name

Name:______________________ Beginning Date:______________________

Attending Nurse:____

Attending Physician:____

Date	Weight	Fatigue	Short of Breath or Cough?	Foot or Ankle Swelling?	Difficulty Sleeping?	Activity Level?	Temp	Pulse	B/P	Resp.

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Patient Scorecard

Your Agency Name

Date	Weight	Fatigue	Short of Breath or Cough?	Foot or Ankle Swelling?	Difficulty Sleeping?	Activity Level?	Temp	Pulse	B/P	Resp.

Completion Date:_______________________________

Patient Signature:____

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Patient Scorecard

Your Agency Name

Name:____________________ Beginning Date:____________________

Attending Nurse:____

Attending Physician:____

Date	Weight	Fatigue	Short of Breath or Cough?	Foot or Ankle Swelling?	Difficulty Sleeping?	Activity Level?	Temp	Pulse	B/P	Resp.

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Patient Scorecard

Your Agency Name

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Date	Weight	Fatigue	Short of Breath or Cough?	Foot or Ankle Swelling?	Difficulty Sleeping?	Activity Level?	Temp	Pulse	B/P	Resp.

TAG Partners

Completion Date:________________________________

Patient Signature:________________________________

Patient Scorecard

Your Agency Name

Name:______________________ Beginning Date:______________________

Attending Nurse:____

Attending Physician:____

Date	Weight	Fatigue	Short of Breath or Cough?	Foot or Ankle Swelling?	Difficulty Sleeping?	Activity Level?	Temp	Pulse	B/P	Resp.

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Patient Scorecard

Your Agency Name

Date	Weight	Fatigue	Short of Breath or Cough?	Foot or Ankle Swelling?	Difficulty Sleeping?	Activity Level?	Temp	Pulse	B/P	Resp.

Completion Date:______________________________

Patient Signature:______________________________

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Patient Scorecard

Your Agency Name

Name:____________________ Beginning Date:____________________

Attending Nurse:____________________

Attending Physician:____________________

Date	Weight	Fatigue	Short of Breath or Cough?	Foot or Ankle Swelling?	Difficulty Sleeping?	Activity Level?	Temp	Pulse	B/P	Resp.

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Patient Scorecard

Your Agency Name

Date	Weight	Fatigue	Short of Breath or Cough?	Foot or Ankle Swelling?	Difficulty Sleeping?	Activity Level?	Temp	Pulse	B/P	Resp.

Completion Date:______________________________

Patient Signature:____

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Notes

Keeping accurate records of your health throughout the year will help your physician and health care providers make better informed decisions regarding your care.

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Statement of Nondiscrimination

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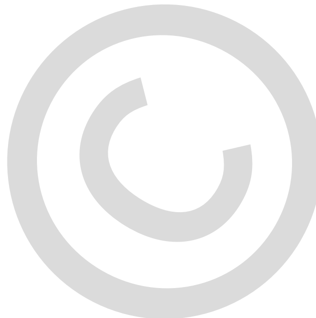

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