MEDICAL
BINDER

MEDICAL
INFORMATION

PRIMARY DOCTOR		PREFERENCES
Name		Emergency Contact:
Address		
Phone		Hospital:
Email		Pharmacy:
DENTIST		**PERSONAL INFO**
Name		
Address		
Phone		
Email		
PEDIATRICIAN		**MEDICAL CONDITIONS & ALLERGIES**
Name		
Address		
Phone		
Email		
VETERINARIAN		
Name		
Address		
Phone		
Email		
OTHER		
Name		
Address		
Phone		
Email		

INSURANCE		INSURANCE	
Company:	Company:	Company:	Company:
Policy:	Policy:	Policy:	Policy:

MEDICAL
CONTACTS

DOCTOR:

DOCTOR:

DOCTOR:

DOCTOR:

WEIGHT LOSS
TRACKER

STARTING WEIGHT: _ _ _ DATE: _ _ _ _

DATE	WEIGHT	BMI	WAIST	HIPS	NOTES