

Binder Updates

I began using this binder on ____ / ____ / ____ (MONTH / DAY / YEAR).

Last Updated Dates:

Notes:

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Clinical Trial Information

Date Found: ____ / ____ / ____ (MONTH / DAY / YEAR)

Trial Name (TITLE): _____

Source of Information (WEBSITE, ETC.): _____

Head Researcher / Physician Name: _____

Phase: _____

Trial ID #: _____ Location: _____

Purpose of the Study (TREATMENT, PREVENTION, DIAGNOSIS): _____

Length of Trial: _____

Eligibility Criteria: _____

Do they pay / reimburse for time and travel costs? Time Travel Both Amount (or percentage): _____

Contact Name: _____ Email: _____

Phone Number(s): (_____) _____ (_____) _____

Contact Name: _____ Email: _____

Phone Number(s): (_____) _____ (_____) _____

Notes: _____

Clinical Trial Questions

Other Questions You May Want to Ask the Head Researcher / Physician

How frequently do I have to visit the hospital / research center? (Once a month, once a week) _____

Has the medication been tested before? Yes No

What is the likelihood that the drug will actually help? (Only ask if phase 3 trial) _____

Who oversees participants' care during the trial? _____

What tests and treatments are involved? _____

Who is funding this study? _____

May I take other Alzheimer's treatments while participating? Yes No

Are there any surgical or other medical procedures involved in the study? Yes No

If you have to draw blood, how much will be drawn? (less than 20 milligrams is a small amount) _____

Will I be able to learn about the treatment I was on after the study is over? Yes No

Does the consent form describe all of the drug's side effects? Yes No

Can I choose to join another drug trial to receive the treatment after this study ends?
(This is called an "open-label" trial, where you know what drug you are taking) Yes No

Will I receive any follow-up care after the study ends? Yes No

Will the trial report all of my test results to my personal doctor? Yes No

Insurance Coverage for Health Procedures

Date: ____ / ____ / ____ (MONTH / DAY / YEAR)

Procedure: _____

Health Care Professional: _____

Health Care Professional Specialty: _____ Phone Number: (____) _____

Do I Need Insurance Pre-Approval? Yes No

Insurance Coverage for This Procedure

Primary Insurance

Company Name: _____ Phone Number: (____) _____

Name of Representative(s) I spoke to: _____

Insurance will Cover This Amount: \$ _____ . ____ or _____ %

My Co-Insurance Amount: \$ _____ . ____ or _____ %

My Co-Pay Amount: \$ _____ . ____

Secondary Insurance

Company Name: _____ Phone Number: (____) _____

Name of Representative(s) I spoke to: _____

Insurance will Cover This Amount: \$ _____ . ____ or _____ %

My Co-Insurance Amount: \$ _____ . ____ or _____ %

My Co-Pay Amount: \$ _____ . ____

Notes: _____

Personal Medical History

Condition / Disease	Date Diagnosed (be as specific as possible)
Allergies (to medications, foods, etc.)	
Arthritis	
Asthma	
Dementia (formal diagnosis of Alzheimer's or related dementia)	
Depression	
Diabetes, Type 1 or 2	
Cancer (List type)	
Cataracts	
Fracture (Hip, Wrist, Spine)	
Glaucoma	
Hearing Loss	
Heart Attack	
High Blood Pressure	
Macular Degeneration	
Osteoporosis	
Urinary Incontinence	
Stroke	
Other (use separate sheet if necessary)	

I currently smoke. Yes No

If yes, number of cigarettes / cigars / pipe per day: _____

No I do not smoke but have smoked in the past, and stopped smoking (age, year): _____

On average, I drink _____ alcoholic beverages per day.

Surgeries / Operations

Date	Surgery (Operation)

Other Hospitalizations

Date	Reason

Family Medical History

Family history includes grandparents, parents, or siblings

Condition / Disease	Relation to Me and Age Diagnosed (if known)
Arthritis	
Asthma	
Dementia (Alzheimer's or other dementia)	
Depression	
Diabetes, Type 1 or 2	
Cancer (List type)	
Cataracts	
Fracture (Hip, Wrist, Spine)	
Glaucoma	
Hearing Loss	
Heart Attack	
High Blood Pressure	
Macular Degeneration	
Osteoporosis	
Urinary Incontinence	
Stroke	
Other (use separate sheet if necessary)	

Resource Notes

Date: ____ / ____ / ____ (MONTH / DAY / YEAR)

Specific Topic: _____

New Resource? Yes No

Type of Source: Website Book Journal Other: _____

Source Information (TITLE, AUTHORS, ETC.): _____

Location of Source (LOCAL LIBRARY, HOME, ETC.): _____

Notes / Key Points: _____

Next Steps (i.e. create new chart, ask health care provider about new treatment, review home safety checklist):

My Alzheimer's Plan

I, _____, know that I still have many enjoyable years ahead.
This is my plan to get the most out of these years.

My plan to remember things I need to do daily includes (use sticky notes, creating a calendar, etc.):

1. _____
2. _____
3. _____
4. _____

To keep my brain active, I will:

1. _____
2. _____
3. _____
4. _____

To stay physically active, I will:

1. _____
2. _____
3. _____
4. _____

A list of people I would like to visit at least once a month includes:

Name: _____ Phone Number: (____) _____
Name: _____ Phone Number: (____) _____
Name: _____ Phone Number: (____) _____
Name: _____ Phone Number: (____) _____

Other goal and plans that I have include: _____

Document Locations

Document	Where it is Stored
Birth Certificate	
Debts and Liabilities (credit cards, loans)	
Divorce Decree	
Do Not Resuscitate Form	
Durable Power of Attorney, Estate and Financial	
Durable Power of Attorney, Health Care	
Financial Statements (savings, checking, investments)	
Guardianship Directives	
Inheritance Information	
Insurance Policies	
Living Will	
Marriage Certificate	
Medical Records	
Military Papers	
Monthly Bill Information	
Mortgage Paperwork	
Passport	
Pension and Retirement Paperwork	
Property Deeds	
Social Security and Other Benefit Summaries	
Social Security Card	
Tax Returns	
Trust	
Will	

Health Appointment Form

Scheduling

Appointment Date: ____ / ____ / ____ Time: ____ : ____ AM PM

Name of Health Care Provider: _____ Office Location: _____

Reason for Visit: _____

Before and During the Appointment

Question(s) for My Health Care Provider	Answers (Recorded During Appointment)

Notes, Additional Questions:

Diagnosis Information: _____

Health Care Provider Recommendations: _____

After the Appointment

Medication(s) Prescribed? Yes No How many? _____

*Please note medication details on **Medication and Vaccination List** worksheet*

Test(s) / Procedure(s) Performed: _____

*Please note test and procedure details on **Health Tests Taken** worksheet*

Follow-Up Appointment? Yes No

Date: ____ / ____ / ____ Time: ____ : ____ AM PM

Name of Health Care Provider: _____

Family Information

My Information

Name: _____

Date of Birth: ____ / ____ / ____ (MONTH / DAY / YEAR)

Social Security Number: ____ - ____ - _____

Spouse / Partner

Name: _____

Date of Birth: ____ / ____ / ____ (MONTH / DAY / YEAR)

Social Security Number: ____ - ____ - _____

Date of Marriage: ____ / ____ / ____ (MONTH / DAY / YEAR)

Death / Divorce Date: ____ / ____ / ____ (MONTH / DAY / YEAR)

Children

Name: _____

Date of Birth: ____ / ____ / ____

Contact Information: _____

Name: _____

Date of Birth: ____ / ____ / ____

Contact Information: _____

Name: _____

Date of Birth: ____ / ____ / ____

Contact Information: _____

Name: _____

Date of Birth: ____ / ____ / ____

Contact Information: _____

Name: _____

Date of Birth: ____ / ____ / ____

Contact Information: _____

Name: _____

Date of Birth: ____ / ____ / ____

Contact Information: _____

Grandchildren

Name: _____

Parent's Names: _____

Date of Birth: ____ / ____ / ____

Contact Information: _____

Name: _____

Parent's Names: _____

Date of Birth: ____ / ____ / ____

Contact Information: _____

Name: _____

Parent's Names: _____

Date of Birth: ____ / ____ / ____

Contact Information: _____

Name: _____

Parent's Names: _____

Date of Birth: ____ / ____ / ____

Contact Information: _____

