My Health and Wellness Record

COW CREEK BAND
OF UMPQUA TRIBE OF INDIANS

PUBLIC HEALTH

Welcome to Your Health and Wellness Record

Do you know your medical history? What about the names and dosages of your medications? Any allergies, what kind of reaction do you have?

These are just a small sample of the questions that medical providers, especially in the hospital, ask a new patient. Often, patients come to the hospital or medical appointments unable to answer health related questions in a meaningful way.

When family members attempt to obtain health documents, they are usually blocked by privacy laws and records are scattered or in obscure places for "safe keeping". Making things even more difficult, for both the patient and medical staff, different electronic health record systems don't always share information. To frustrate matters further, medical records may only be accessible during business hours. Illness and injury do not wait for Monday morning at 9 AM; instead, it happens during weekends, late nights, early mornings and holidays. Knowing and having some understanding of your medical history is essential to getting safe and effective medical care.

To help address these issues, the Cow Creek Umpqua Public Health team has worked to create this health and wellness packet to empower patients to take responsibility for managing their own medical care.

The Public Health team has a combined experience of 48 years in the nursing field. We hope that our knowledge and experience have created a product that will help you to manage your healthcare in a format that is useful for you and your medical provider. This packet should serve as a guide to health preparedness and understanding for people of all ages.

As nurses, we know the medical system can be difficult to navigate and that medical conditions are complicated to understand. We are here to educate and serve the people of our community in their quest for health and wellness.

Sincerely,
Your Public Health Team:

Sarah Frieler Email: sarah.frieler@cowcreek-nsn.gov
Debi Groshong Email: debi.groshong@cowcreek-nsn.gov
Arika Tenbrook Email: arika.tenbrook@cowcreek-nsn.gov

Get the Most from Your Health and Wellness Record

Where to Find More Pages

In each section of your Health and Wellness Record, you'll find useful forms, instructions, and how many of each page to print. To print more of each sheet, visit our webpage at www.cowcreek-nsn.gov/health/public-health/ and download the digital version of this binder, then print the pages that you need.

How Often to Use This Packet

This packet is a tool that can be used daily, weekly, yearly, or as needed. It has the capacity to change as you age and expand as medical conditions become more complicated. It is also set up for caregiver use, in the event you become unable to make your own decisions or manage your own care.

Instructions for Use

At the beginning of each section, you will find instructions on how to use its contents, as well as tips about obtaining items not included with the packet.

Before filling out this packet, it is recommended that you read the "Getting the Most from Your Health and Wellness Record" and "Helpful Terminology" sheets included at the start of most of the sections.

Where to Store This Packet

This packet should be kept in a safe place that is easy to access when needed and at least one person you trust should know where you keep it. If you are elderly or have extensive medical needs, it is a good idea to take this with you when traveling.

Stay Prepared

Keeping a hard copy of your medical record may seem like something from the past, but rest assured it is still important. Having a hard copy of your medical record is also one essential step in personal emergency preparedness.

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Personal Health Information

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Get the Most from Your Health and Wellness Record

Personal Health Information

Medical Information Sheet: Print 1 page

This is a form like what you find in your chart at the doctor's office or hospital. Filling this out could help medical providers quickly learn basic information about you. It could also help your family if you were incapacitated.

Allergies: Most people will only need to print 1 page

It is important to understand the difference between an allergy and a side effect or adverse reaction. Please refer to the Helpful Information and Terminology page to learn the difference so you can accurately record allergies to medications and foods.

Adverse Reactions and Food Sensitivities: Most people will only need to print 1 page

The adverse reactions and food sensitivities page should be filled out in a similar manner to the allergies page.

Medical History: Print 1 page

This page is a way of collecting your general health history to help build a picture of your overall health.

1. On this page, you will start by listing your chronic or ongoing medical conditions. If you have many chronic illnesses, you can add an additional sheet of paper to list your conditions.
2. List any family medical conditions that affect your blood relatives. For example, a family history of breast cancer and whoever was diagnosed, are important pieces of information. If your doctor knows about family history, they can be more proactive with preventative screenings and treatments.
3. If you know it, list your blood type. Usually, blood type is not something you need to know; if you need blood the lab will test it or give you blood from a universal donor.

4. Substance use is the next topic. To the best of your ability, fill out the chart regarding your substance use. Make sure to list alcohol, tobacco, vaping, drug, and marijuana use.
    a. While it may be difficult to be honest about substance use, it is critical for healthcare providers to know.
    b. For example, withdrawal from alcohol can be dangerous without proper medical management. If your healthcare providers are unaware of alcohol use or if you have not been honest about how much, they cannot assess or treat you properly. Substances can interact with medications that your healthcare provider prescribes, so it is important that substance use is accurately communicated with them.
5. Next, you will answer questions about your diet. This is a good place to list if you are gluten free, vegetarian, vegan, or if you have any other diet preferences.
    a. Some people need liquids to be thickened or foods to be pureed, this is where you should put that information.
    b. How you take your pills is also important (whole with water, crushed and/or in applesauce).
    c. Even if you have no difficulty remembering this information, it is important to fill it out just in case you find yourself in a situation where you are unable to provide it.

Recent History and Physical:

You can ask for a history and physical printout from your doctor's office. A history and physical is your doctor's documentation based on your most recent exam. If you are hospitalized, this is helpful because it can be difficult for patients to relay medical information to medical providers in a meaningful way.

POLST/ Advanced Directive/ Power of Attorney/ Guardianship:

These items are not included in the packet, and should be obtained from other sources. Sources are listed on the Helpful Information and Terminology Sheet for this section. You should keep originals of these papers in a safe place that does not leave your home, and copies should be kept in this binder.

Helpful Information and Terminology

Allergy
Abnormal or excessive response by the immune system to a usually harmless substance that gets into the body. People can have allergies to any medication or substances (bee stings, latex, pollen). Allergy symptoms include (but are not limited to): hives, itching, rash, runny nose, watery eyes, difficulty breathing, wheezing, and swelling of your face, nose, tongue, or throat. Nausea and vomiting can be signs of allergic reaction, but often are side effects of medication rather than a true allergy. Anaphylaxis is a severe allergic reaction that is potentially life-threatening.

Adverse Reaction
Unwanted or undesirable effect of medication or medical treatment. This term is often used to describe reactions to medications that are not considered allergies but are undesirable, nausea for example.

Side Effect
Secondary and usually known effect of a medication.

Food Sensitivity
When the body has difficulty digesting a certain kind of food. Food sensitivities are not allergies because they do not involve the immune system. Lactose is a common food sensitivity. Gluten can also be a sensitivity, but people with Celiac disease have a food allergy.

Supplement
A substance that completes or enhances the nutrition you get from your food. Vitamins and minerals are supplements. Since supplements are not FDA regulated, it is a good idea to look for supplements with USP certification. Some supplements require a prescription, but many of them can be purchased over the counter.

Medication
Medications are drugs used to diagnose, treat, or prevent disease. These can be purchased over the counter or prescribed by a doctor. Drugs or medications are subject to strict regulation and must be approved for use by the FDA. Examples of medications/drugs include—but are not limited to—pain medication, blood pressure medication, contrast for imaging, chemotherapy, vaccines etc. In this context “drugs” does not refer to illicit or illegally obtained or used substances.

Chronic Condition
A health condition that is long term, usually lasting more than a year and requiring ongoing medical attention. Examples include heart disease, diabetes, PCOS, asthma, liver disease.

Family Medical History
Medical history of a person’s blood relatives.

Helpful Information and Terminology

POLST (Portable or Physician Orders for Life-Sustaining Treatment)

A legally binding medical order that helps people to determine what care they want and don't want, when/if they become unable to make their own decisions. Your primary care provider can assist you with this document. A copy should be kept in this binder; the original should be kept in a safe location that does not leave your home.

Advanced Directive or Living Will

Form or document that allows a person to set guidelines and directives for care if they become unable to make their own decisions. This is different from a from POLST because it is not a legal medical order. This form and instructions for use can be found online at Oregon.gov/oha/ph/about/pages/adac-forms.aspx

Power of Attorney (POA)

Power of Attorney is a legal document that gives permission to an individual to make decisions in your place. Designating a POA gives you the ability to choose who makes life or death decisions in the case you become unable to direct your own medical care or finances. It is best to consult an attorney to complete this paperwork. Keep a copy in this binder and the original in a safe location that does not leave your home. Additional information can be found at osbar.org/public/legalinfo/1122-powerofattorney.htm

Guardian

Someone who is legally appointed and responsible to care for, or act in a person's best interest, due to age (minor) or incapacity (adult/disabled person). Guardianship is often needed if someone does not have a POA and becomes incapacitated. Guardianship can take months to obtain, resulting in delayed care. A copy of any paperwork should be kept in this binder, and the original should be kept in a safe place that does not leave the home.

Code Status

Full code means you wish to have all life-saving treatment if your heart or breathing were to stop, including cardiopulmonary resuscitation (CPR), intubation and mechanical ventilation, defibrillation (shock to restore heart rhythm), medications and any other needed treatments.

Limited code means you will allow some life saving interventions but not others. For example, you may want medications and defibrillation but not CPR.

Do Not Resuscitate (DNR) means that you do not want any life-saving interventions if your heart or breathing stop. If you are a DNR you will still be given full care until your heart or breathing stops, but after that medical professionals will not attempt resuscitation.

Comfort measures only means the only care that will be provided is care that keeps the person comfortable. No life saving or life extending treatments will be provided.

Medical Information Sheet

PERSONAL INFORMATION	
Name	
Date of Birth	
Address	
Living Situation	☐ Home ☐ Assisted Living ☐ Nursing Home ☐ Single ☐ With Someone ☐ Other *(Please specify)*:
Phone Number	
Email	
Religion/Spirituality	

Emergency Contacts			
Primary Emergency Contact		**Secondary Emergency Contact**	
Name		Name	
Relationship		Relationship	
Phone Number		Phone Number	
Address		Address	

Insurance Information			
Primary Insurance		**Secondary or Supplemental Insurance**	
Carrier Name		Carrier Name	
ID Number		ID Number	
Group Number		Group Number	
Phone Number		Phone Number	

Location of Important Documents	
Advanced Directives	
Living Will	
DNR	
POLST	

Code Status	☐ Full ☐ DNR ☐ Limited

Allergies

Medication Allergies

Medication	Reaction
Example: Lisinopril	*Example: Tongue Swelling*

Non-Medication Allergies *(Include food allergies here)*

Allergen	Reaction
Example: Latex	*Example: Difficulty breathing and hives*

Adverse Reactions and Food Sensitivities

Medication Adverse Reactions *(Non-allergic, but undesired effect)*

Medication	Reaction
Example: Oxycodone	*Example: Nausea and vomiting*

Food Sensitivities *(Foods you don't tolerate well, but are not allergic to)*

Food	Reaction
Example: Milk/Lactose	*Example: Gas and bloating*

Medical History

Blood Type	

Your Chronic Conditions and Medical History *(Heart disease, diabetes, cancer, etc.)*

Example: Diabetes - diagnosed in 2021 (date of diagnosis optional)

Family Medical History *(Parents, Siblings)*

Example: Mother had breast cancer

Substance Use

(One drink is: 12oz of beer with 5% alcohol, 8 ounces of malt liquor with 7% alcohol, 5 ounces of wine with 12% alcohol, a shot or 1.5 ounces of liquor with 40% alcohol or 80 proof.)

Substance	Frequency	Quantity

Diet

Do you follow a specific diet or have any restrictions?	
What liquid consistency do you need for safe swallowing? *(e.g. liquid, nectar, honey, N/A)*	
Do you have any difficulty with textures or chewing?	
How do you take your pills?	

Preventative Care

Contents

- **Immunization Records** (Obtain from Doctor)
- **Preventative Screenings and Procedures**

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Get the Most from Your Health and Wellness Record

Preventative Care

Immunization Records:

Your doctor's office can help you obtain these records. It is convenient to have a current immunization record on hand for travel and when starting a new job.

Preventative Screenings/Procedures: Start with one page and print more as needed.

Keep track of all your preventative screenings and procedures in this section. Record dates and details about prostate exams, mammograms and colonoscopies. You can also request printouts of reports from screenings and procedures to keep in this section.

Preventative Screenings and Procedures

Date	*Ex: 8/18/2025*	**Screening/ Procedure**	*Example: Colonoscopy*
Notes	*Example: Tolerated anesthesia well. One polyp was removed, no cancer.*		

Date		**Screening/ Procedure**	
Notes			

Date		**Screening/ Procedure**	
Notes			

Date		**Screening/ Procedure**	
Notes			

Date		**Reason/ Procedure**	
Notes			

Date		**Screening/ Procedure**	
Notes			

Medications and Supplements

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Medications and Supplements

Medication List (Scheduled/ As Needed): Print as many pages as you need

This page should be used to list all your current medications, the dose, frequency of use, purpose, prescriber and any special instructions.

- If you no longer take a medication, use a red pen to put a line through the medication; under the special instructions section would write “stopped” and the date the medication was discontinued.
- List medications you take routinely first, then any medications you take as needed. It may be helpful to have a page for scheduled/routine medications and a separate page for as-needed medications.
- For any changes, put a red line through the information, then write the new dose or information. If you like a cleaner look, you can also rewrite the page any time you make changes.

Supplement List: Print as many pages as needed

Use this page to write down the full name of any supplements you use. Include the dose you take, you may need to read the dosing instructions on the bottle so you can accurately record what you take.

Be sure to include any unit measurements like milligrams (mg) or international units (iu). Include the reason for use and any special instructions.

Medication Administration Record: You will need to print new pages each month.

Not everyone will need this page, but it is helpful if someone else manages your medications or you have difficulty remembering to take your medications.

On this page, you will list your medications down one side of the page. Each day when you take your medication, leave a mark after you take the medication. You can use check marks, stars, slashes or any symbol you would like to indicate that you took the medication.

If you do not take your medication, leave the box blank for that day.

Helpful Information and Terminology

Scheduled Medication
A medication that is taken on a set routine.

PRN
Medication that is taken as needed.

PO
Medication that is taken orally

PR
Medication that is administered rectally.

Subcutaneous, SC, SUBQ Injection
Medication that is administered by injection under the skin into the fatty tissue.

Intramuscular, IM Injection
Medication that is administered by injection into the muscle.

Medication List

Include scheduled, routine, as needed, and over-the-counter medications in this section.

MEDICATION	DOSAGE	FREQUENCY	ROUTE OF ADMINISTRATION	PURPOSE	PRESCRIBER	SPECIAL INSTRUCTIONS, START/ STOP DATES, SIDE EFFECTS
Example: Spironolactone/ Aldactone	*Example: 25mg*	*Example: Daily*	*Example: Oral*	*Example: Lower blood pressure*	*Example: Michelle Phelps*	*Example: Do not take if the top number of your blood pressure is less than 100 or if you feel dizzy or lightheaded*

NOTES

Supplement List

Include all supplements and herbal remedies in this section.

SUPPLEMENT	SERVING SIZE OR DOSAGE	FREQUENCY	REASON FOR USE	SPECIAL INSTRUCTIONS
Example: Vitamin D3 1000 IU or 25 mcg capsules	*Example: 1 capsule*	*Example: Daily*	*Example: Vitamin D replacement*	*Example: Include any special instructions from your medical provider or pharmacist*

NOTES

Medication Administration Record

Patient Name		Month Recorded	

DATE	MEDICATION ORDER (Dose, Frequency, Site, Route)	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
START *Ex: 8/18*	*Example: Metoprolol, 25 mg, twice daily, oral*	*Ex:8 AM*																		X	X	X	X	X	X	X	X	X	X	X	X		
		Ex:5 PM																		X	X	X	X	X	X	X	X	X	X	X	X		
STOP *Ex: 8/30*																																	
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Whenever you take your medication, mark the box in the row of the time you took it, in the column of the day of the month in which you took it.
If you have more medications than there are available spaces, print additional sheets for your binder.

Health Tracking

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Health Tracking

Blood Pressure Record: Start with one page, and print more as needed.

At home blood pressure monitoring is important to everyone's health, especially as we age.

- A blood pressure reading only gives information in the moment the pressure was taken. If you monitor your pressure frequently, over time you can track trends in your pressure, and your doctor can better understand if you need medication or how the medications are working.
- The position you are in (sitting, lying, standing) can affect your blood pressure; record what position you are in when you check your blood pressure. Your blood pressure reading will be most accurate if you sit or lay down for five (5) minutes before checking it. If you are having symptoms of abnormal blood pressure, check your pressure immediately; do not wait.
- Symptoms or details at the time of the blood pressure measurement can provide context for your provider; for example, if you got lightheaded when standing, that is important context for your provider.

Personal Health Tracking Chart: Start with one page, and print more as needed.

This chart helps you to track other health metrics, like your weight, cholesterol, A1c, and any other information you wish to track over time. This chart will help you see how your body and health are changing as you age. Many of these metrics will be checked every few months to every year. Waist measurement, weight, and BMI are things you can calculate at home if you choose.

Medical Event or Symptom Record: Start with one page, and print more as needed.

When people are having medical issues, it can take time to make a proper diagnosis. It can be helpful to keep a symptom or event journal. Symptom records can also be used to track mood and mental health symptoms.

For example, if you intermittently become dizzy or lightheaded it is important to write down details of the event. An entry could read: "I stood up after watching a TV show, I instantly felt dizzy, and my heart started racing." Brief but descriptive context is important for medical providers to understand your symptoms and help determine what may be going on.

Even if you do not have any current medical concerns, you should have this sheet of paper in your packet in the event you do have a medical event or symptom. Details are easy to forget, so it is best to write down medical events as soon as possible.

Blood Glucose Log (optional): Start with one page, and print more as needed.

Not everyone will find this page useful; however, it could be helpful, especially if you do not have a continuous glucose monitor. Writing down your blood glucose levels and details could provide important context and understanding of how your blood sugar is trending, or how it is affected by the foods you eat. This could also help your provider understand what is going on between a1c checks. During times of illness, this chart can be used to track trends and monitor your blood glucose more closely.

Helpful Information and Terminology

Systolic Blood Pressure
Top number of the blood pressure that is generated when the heart is actively pumping. Target number is less than 120 and greater than 90.

Diastolic Blood Pressure
Bottom number of the blood pressure is generated when the heart is at rest between beats. Target number less than 80 and greater than 60.

Cholesterol
A waxy substance of proteins and fats that is created in the liver for use in the body. Cholesterol is used to build cell walls, make bile salts that help break down fat, create vitamin D, used in hormone production, and used in the nervous system. Total cholesterol should be less than 200.

Low Density Lipoprotein (LDL, Bad Cholesterol)
Transports cholesterol to other parts of the body. Healthy range: 100 or less.

High Density Lipoprotein (HDL, Good Cholesterol)
Transports cholesterol back to the liver to be broken down then excreted.

Triglycerides
A kind of fat (lipid) found in the blood; it is stored as fat. Excess calories from sugar and alcohol are turned into triglycerides in the body. Fats like butter are in triglyceride form. Healthy range 150 or less.

Hemoglobin A1c
Test that shows your average blood glucose level over a two-to-three-month period.

Blood Pressure Record

DATE	TIME	BLOOD PRESSURE	HEART RATE	SITTING, STANDING, OR LYING?	SYMPTOMS OR DETAILS
Ex: 8/30	*Ex: 9 AM*	*Example: 120/80*	*Example: 75*	*Example: Sitting*	*Example: No symptoms / daily check*
Ex: 8/31	*Ex: 9 AM*	*Example: 85/40*	*Example: 110*	*Example: Sitting*	*Example: Stood and felt dizzy or faint*

Personal Health Tracking Chart

DATE					
WEIGHT					
BODY MASS INDEX (BMI)					
NECK MEASUREMENT					
BUST MEASUREMENT					
HIP MEASUREMENT					
WAIST MEASUREMENT					
THIGH MEASUREMENT					

DATE					
TOTAL CHOLESTEROL					
LDL					
HDL					
TRIGLYCERIDES					
A1C					

You may use the blank rows for other labs or metrics

Medical Event or Symptom Record

DATE	TIME	NOTES
Example: 8/18/25	*Example: 8 AM*	*Example: I felt dizzy when standing up, and my heart started racing.*

Blood Glucose Log

Month and Year: _____

DAY	BREAKFAST	LUNCH	DINNER	BEDTIME	OTHER TIME	COMMENTS
Example	*Ex: 50*					*Woke up feeling shaky.*
1						
2						
3						
4						
5						
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Hospitalizations, Surgeries, Procedures, and Medical Implants

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Hospitalizations, Surgeries, Procedures, Medical Implants

Implanted Medical Devices: You do not need to print this page if you have no implanted devices.

It is important to be aware of any implanted medical devices. Implanted medical devices include, but are not limited to pacemakers, joint replacements, heart valves and nerve stimulators. It is also important to know the ID number or serial number for the device. Make it a priority to know any restrictions you have after the implant is placed, and how long that restriction should be followed.

Hospitalizations, Surgeries, and Procedures: Start with one page, print more as needed.

Fill this page out with the date range of hospitalization, reason for hospitalization, and any notes about the stay. This can be helpful since people often do not remember much about a stay in the hospital. Also, include dates and reasons for surgeries and procedures (like biopsies). If you prefer, you can keep a separate page each for hospitalizations, surgeries, and procedures.

Implanted Medical Devices

(Pacemaker, Nerve Stimulator, Heart Valve, Joint Implant, etc.)

Implanted Device	*Example: Pacemaker*
ID Number	*Example: 111111111*
Date of Procedure	*Example: 8/18/2025*
Reason for Implant	*Example: Symptomatic bradycardia (low heart rate with symptoms)*
Restrictions/Notes	*Example: Do not lift more than 10 pounds for 6 weeks after the procedure.*

Implanted Device	
ID Number	
Date of Procedure	
Reason for Implant	
Restrictions/Notes	

Implanted Device	
ID Number	
Date of Procedure	
Reason for Implant	
Restrictions/Notes	

Implanted Device	
ID Number	
Date of Procedure	
Reason for Implant	
Restrictions/Notes	

Hospitalizations, Surgeries, and Procedures

Date	*Example: 8/15/25*	**Reason/ Procedure**	*Example: Appendix removal*
Notes	*Example: Took ambulance to hospital after appendix burst. Tolerated anesthesia well. Appendix was removed.*		

Date		**Reason/ Procedure**	
Notes			

Date		**Reason/ Procedure**	
Notes			

Date		**Reason/ Procedure**	
Notes			

Date		**Reason/ Procedure**	
Notes			

Date		**Reason/ Procedure**	
Notes			

Primary Care and Specialists

Contents

- **Appointment Record**
- **Provider Profile**
- **Appointment Summary** (Keep your summary from each visit behind the corresponding provider profile)

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Get the Most from Your Health and Wellness Record

Primary Care and Specialists

Appointment Record: Start with one page, and print more as needed.

This chart should be used as a quick reference to keep track of any primary care or specialist visits. Just write down the date, purpose of the visit, and any notes you have. This will help you keep track of routine appointments.

Provider Profile: Print one sheet for each doctor you see.

A provider profile is a sheet of paper that you can fill out with information about your doctor, as well as their location and contact information. Under this section you should keep a provider profile for your primary care doctor and every specialist you see, **except** your eye doctor, dentist, and mental health professionals; those profiles should be kept under the "Vision," "Dental," and "Mental Health" sections. There is also room to put a photo of your doctor, if you find that helpful.

Appointment Summaries: Print ten copies so that you have them on hand for appointments.

An appointment summary is helpful to prepare for your appointment and to take notes during and after the appointment. Appointments with medical providers are usually about 15 minutes long. Often changes are made to your medications or care during the appointment. It can be beneficial to write things down during the appointment or soon after while details are fresh in your mind. You may choose to use only the Appointment Record, Appointment Summary, or both.

Appointment Record

DATE	PURPOSE	NOTES
Ex: 8/8/25	*Example: Yearly check-up*	*Example: Blood pressure was high, reduce salt intake and get lab draws on 9/5/25.*

Provider Profile

Provider's Name

Clinic

Address

Provider Photo

Phone

Email

Why do I see this doctor?

Appointment Summary

Doctor's Name	
Appointment Date and Time	
Address	
I have scheduled this appointment because	
Symptoms I want to discuss	
Questions I want to ask	
Notes (Medication changes, doctor comments, recommendations, etc.)	
My To-Do List	

Dental

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Get the Most from Your Health and Wellness Record

Dental

Appointment Record: Start with one page, and print more as needed.

This chart should be used as a quick reference to keep track of dental appointments. Just write down the date, purpose of the visit, and any notes you have. This will help you keep track of routine appointments, such as your most recent dental cleaning.

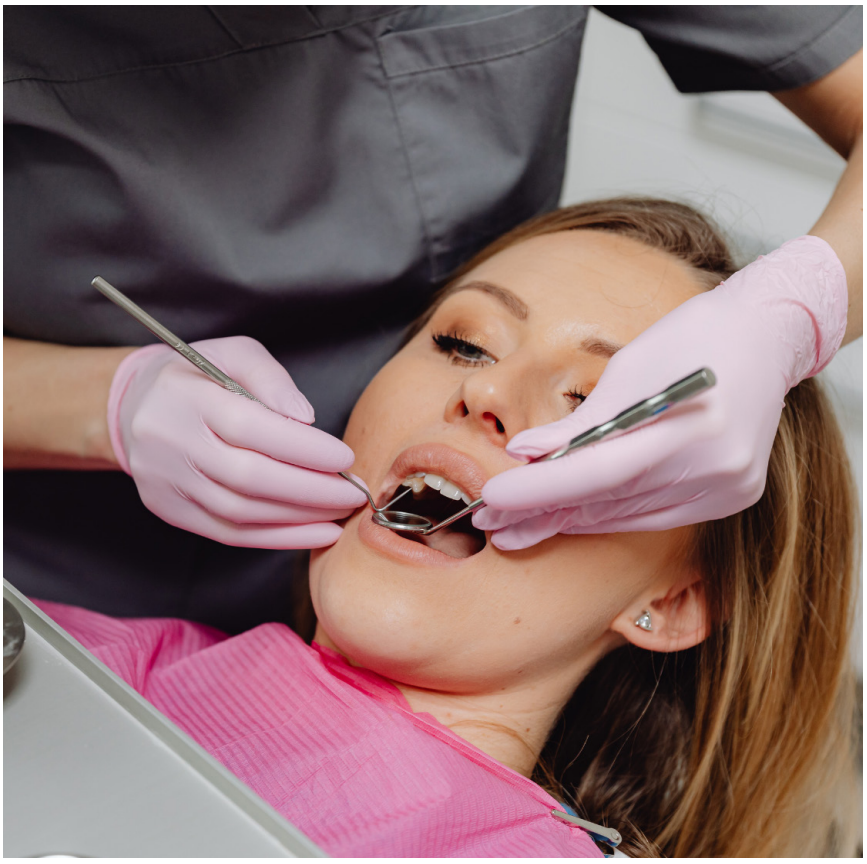
Provider Profile: Print one sheet for each dentist you see.

Under this section you should keep a provider profile for any dentists you see. A provider profile is a sheet of paper that you can fill out with information about your doctor, as well as their location and contact information. There is also room to put a photo of your dentist, if you find that helpful.

Appointment Summaries: Print ten copies so that you have them on hand for appointments.

An appointment summary is helpful to prepare for your appointment and to take notes during and after the appointment. Appointments with the doctor are usually about 15 minutes long. Often changes are made to your medications or care during the appointment. It can be beneficial to write things down during the appointment or soon after while details are fresh in your mind.

You may choose to use the Appointment Record, the Appointment Summary, or both forms.



Provider Profile

Provider's Name

Clinic

Address

Provider Photo

Phone

Email

Why do I see this doctor?

Appointment Record

DATE	PURPOSE	NOTES
Ex: 8/8/25	*Example: Cleaning*	*Example: Follow-up appointments are needed to fill cavities.*

Appointment Summary

Doctor's Name	
Appointment Date and Time	
Address	
I have scheduled this appointment because	
Symptoms I want to discuss	
Questions I want to ask	
Notes (Medication changes, doctor comments, recommendations, etc.)	
My To-Do List	

Vision

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COW CREEK BAND OF UMPQUA TRIBE OF INDIANS
PUBLIC HEALTH

Get the Most from Your Health and Wellness Record

Vision

Appointment Record: Start with one page, and print more as needed.

This chart should be used as a quick reference to keep track of vision appointments. Just write down the date, purpose of the visit, and any notes you have. This will help you keep track of routine appointments, such as your most recent eye exam.

Provider Profile: Print one sheet for each eye doctor you see.

Under this section you should keep a provider profile for any eye doctors you see. A provider profile is a sheet of paper that you can fill out with information about your eye doctor, as well as their location and contact information. There is also room to put a photo of your eye doctor, if you find that helpful.

Appointment Summaries: Print ten copies so that you have them on hand for appointments.

An appointment summary is helpful to prepare for your appointment and to take notes during and after the appointment. Appointments with the doctor are usually about 15 minutes long. Often, changes are made to your medications or care during the appointment. It can be beneficial to write things down during the appointment or soon after while details are fresh in your mind.

You may choose to use the Appointment Record, the Appointment Summary, or both forms.

Appointment Record

DATE	PURPOSE	NOTES
Ex: 8/8/25	*Example: Eye exam*	*Example: New prescription for glasses needed. Stop by to pick up new glasses after 9/3/25.*

Provider Profile

Provider's Name

Clinic

Address

Provider Photo

Phone

Email

Why do I see this doctor?

Appointment Summary

Doctor's Name	
Appointment Date and Time	
Address	
I have scheduled this appointment because	
Symptoms I want to discuss	
Questions I want to ask	
Notes (Medication changes, doctor comments, recommendations, etc.)	
My To-Do List	

Mental Health

Contents

My Health and Wellness Record

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Get the Most from Your Health and Wellness Record

Mental Health

Appointment Record: Start with one page, and print more as needed.

This chart should be used as a quick reference to keep track of mental health appointments. Just write down the date, purpose of the visit, and any notes you have. This will help you keep track of routine appointments, such as your most recent therapy session.

Provider Profile: Print one sheet for each mental health professional you see.

Under this section, you should keep a provider profile for any mental health professionals you see. A provider profile is a sheet of paper that you can fill out with information about your mental health professionals, as well as their location and contact information. There is also room to put a photo of your mental health professional, if you find that helpful.

Mood Tracker: Start with one page, and print more as needed.

Record any mental health symptoms or concerns so that you can discuss them with your mental health professional at your next visit.

My Mental Health Resources: Start with one page, and print more as needed.

List contact information of people you can reach out to when you are in emotional distress or having a mental health crisis. You can also list resources that help improve your mental state when you are struggling.

Appointment Record

DATE	PURPOSE	NOTES
Ex: 8/8/25	*Example: Therapy session*	*Example: Discussed triggers of recent depressive episodes. Created plan for managing triggers.*

Provider Profile

Provider's Name

Clinic

Address

Provider Photo

Phone

Email

Why do I see this doctor?

Appointment Summary

Doctor's Name	
Appointment Date and Time	
Address	
I have scheduled this appointment because	
Symptoms I want to discuss	
Questions I want to ask	
Notes (Medication changes, doctor comments, recommendations, etc.)	
My To-Do List	

Mood Tracker

DATE	TIME	NOTES
Example: 8/18/25	*Example: 11 AM*	*Example: After a conversation with my boss, I had an anxiety attack.*

My Mental Health Resources

If I am struggling with my mental health or am in crisis, I can reach out to:

- **Crisis Line - Dial/text 988**
- **Support people**

SUPPORT PERSON 1	
Name	
Phone Number	
SUPPORT PERSON 2	
Name	
Phone Number	
SUPPORT PERSON 3	
Name	
Phone Number	

- **Other Resources**

Imaging, Lab, and Test Results

Contents

- **Any Imaging, Lab, or Test Results** (Obtain from Doctor)

My Health and Wellness Record

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Imaging and Lab Results

Keep any printouts from the lab in this section. Your doctor's office should be able to print these for you, but they can also be accessed on your online patient portal.