Pulmonary Fibrosis Now!

MY TREATMENT PLAN

Name _____
Birth Date _____
Medical Plan _____
Medical Plan ID _____

My Phone Number & Email _____
My Emergency Contact's Name _____
Relationship to Emergency Contact _____
Phone Number for Emergency Contact _____

Known Medical Conditions

Diagnosis	Date of Diagnosis

Allergies

Allergy	Kind of Reaction

Immunizations

Vaccination	Date

Past Surgeries & Procedures

Name of Surgery/Prodecure	Date Completed

Treatment Plan

Treatment or Activity	Yes, No, or Maybe
Healthy diet	
Maintain healthy weight	
Attend support groups	
Pulmonary rehabilitation	
Oxygen supplementation	
Breathing exercises	
Systemic enzymes	
Other dietary supplements	
Mindfulness & meditation	
Medications	
Lung transplant	
Vaccinations	
Yoga	
Acupuncture or acupressure	
Other:	

Medications

Name of Medication	Description	Dosage/Instructions

Dietary Supplements

Name of Supplements	Reason/Description	Dosage/Instructions

Medical Visits or Treatments

Date	Description	Specialist or Physician	Diagnosis	Tests Performed	Test Results	Prescribed Action	Prescribed Medication	Notes