



Doctor's Appointment Organizer

A Caregiver's Binder-Ready Tracking Packet

Patient Name: _____

Caregiver Name: _____

Date Started: _____

Print each section, hole-punch, and organize with tabbed dividers for easy access.

This packet contains 8 tracking sections and a quick-reference contacts page.

Prepared for Aunty Da's House LLC • April 25, 2026

Before You Start

- **Print and prep:** For a binder, print single-sided, hole-punch, and add tabbed dividers (Primary Care, Specialists, Lab/Testing, Dental, Vision, Pharmacy, Therapy/Wellness, Urgent/Emergency).
- **Bring a short “grab list”:** insurance card, photo ID, medication list (including doses), allergies, and your top 3 questions for today.
- **Use one section per visit:** jot notes during the appointment, then circle or highlight next steps at home.
- **Ask for clarity:** it’s okay to request plain-language explanations, written instructions, or a summary in the patient portal.
- **Take care of you, too:** caregiving is real work. Keep water, snacks, and a pen in your bag—small things help.

Important Notes & Disclaimers

- **This packet is for organizing information only. It is not medical advice and does not replace guidance from a qualified healthcare professional.**
- **In an emergency: call your local emergency number right away. Do not delay urgent care while filling out paperwork.**
- **Protect privacy: completed pages may include private health information. Store this binder in a safe place. Avoid emailing photos/scans unless you trust the method and recipient.**
- **Use what fits your situation: every person and every visit is different. Skip pages you don't need and add notes anywhere you want.**
- **Accuracy matters: always confirm medication names/doses and instructions directly with the provider or pharmacy.**

Primary Care Appointments

Regular checkups, wellness visits, annual physicals

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Primary Care Appointments (continued)

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Specialist Appointments

Cardiologist, neurologist, dermatologist, and other specialists

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Specialist Appointments (continued)

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Lab Work & Testing

Blood draws, imaging, screenings, diagnostic tests

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Lab Work & Testing (continued)

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Dental Appointments

Cleanings, procedures, oral health checkups

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Dental Appointments (continued)

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Vision & Eye Care

Optometrist, ophthalmologist, prescription updates

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Vision & Eye Care (continued)

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Pharmacy & Medication Refills

Prescription pickups, refill tracking, medication changes

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Pharmacy & Medication Refills (continued)

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Therapy & Wellness

Physical therapy, occupational therapy, counseling, mental health

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Therapy & Wellness (continued)

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Emergency & Urgent Care Visits

Walk-in visits, ER trips, unplanned medical events

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Emergency & Urgent Care Visits (continued)

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Date: _____

Doctor / Provider: _____

Location / Clinic: _____

Time: _____

Reason for Visit: _____

Notes / Follow-Up: _____

Completed

Quick Reference — Important Contacts

Keep this page at the front of your binder for quick access.

Provider Name	Specialty	Phone	Address

Keep this page at the front of your binder for quick access.

You are doing important, meaningful work as a caregiver. Stay organized and take care of yourself, too.