Make sure you save a copy of the PDF to your computer before you enter any information! You can then save your changes as you go.

TAKE CHARGE

TRANSPLANT

Health Journal

Name | Date

Basic Information

Date of birth	Primary disease	Date of transplant	Total fluid intake	Diet	Pre-transplant			Allergies
					CMV	EBV	BK	

Important Health Contacts

Name	Role/Position	Number
	Choose or type	
	Choose or type	
	Choose or type	
	Choose or type	
	Choose or type	
	Choose or type	
	Choose or type	
	Choose or type	
	Choose or type	

Reminders

	Frequency	Last done	Next due
Blood work	Every 1 month		
Clinic visit	As needed		
Skin check	Every 3 months		
Dentist	Every 6 months		
Ophthalmologist	Every 1 year		
PAP smear*	Every 1 year		

* if female and sexually active

Medications

Name	Dosage	Frequency
Choose medication		Frequency
Choose medication		Frequency
Choose medication		Frequency
Choose medication		Frequency
Choose medication		Frequency
Choose medication		Frequency
Choose medication		Frequency
Choose medication		Frequency
Choose medication		Frequency
Choose medication		Frequency

Missed Medications

Date	Name	Reason
	Choose medication	
	Choose medication	
	Choose medication	
	Choose medication	
	Choose medication	
	Choose medication	
	Choose medication	
	Choose medication	
	Choose medication	
	Choose medication	

My Health Status

Date	Weight	Blood pressure	Creatinine	ALT	Choose other	Choose other

Appointment Log

Date	Clinic / Person	Reason	What I need to remember

Thoughts/Feelings/Questions

Date	Description