eResources4Health™
Committed to health, education, and quality

# My Numbers Tracker

Name: _____ Address: _____

Phone: _____ Healthcare Provider: _____

Email: _____ Healthcare Provider Phone: _____

## ALLERGIES

_____

_____

## MY MEDICAL HISTORY

Check all those that apply:

- ❑ Overweight/Obese
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ High Cholesterol
- ❑ Kidney Disease
- ❑ Other _____

**MY NUMBERS CHART:** Ask your doctor or nurse to help you complete the following chart

| My Numbers | Month _____ | Month _____ | Month _____ | My Goal |
|---|---|---|---|---|
| **Weight:** | | | | |
| **BMI:** | | | | |
| **Blood Pressure:** | | | | |
| **Fasting Blood Glucose:** | | | | |
| **A1C:** | | | | |
| **Total Cholesterol:** | | | | |
| **HDL Cholesterol:** | | | | |
| **LDL Cholesterol:** | | | | |
| **Triglycerides:** | | | | |