

Medical Records + AI Clinical Record

Tools for navigating care — not replacing it.

Google Drive Setup Guide & Master Prompt

Put every medical record in one place and let AI fill in your Clinical Record workbook

Inside this guide

- How to gather every medical record you have
- How to build a private Google Drive folder that holds them all
- How to create a safe Google Drive link (and the one setting never to use)
- Three ways to get your records into ChatGPT, Claude, or Perplexity
- Privacy settings to check before you upload
- The complete copy-and-paste Master Prompt that fills in all 25 tabs of the Clinical Record workbook
- An Update Prompt for new visits and a Google Drive Link Prompt

Your information stays with you.

SynquUp does not receive, collect, store, or have access to anything you add. Your records stay in your own Google Drive, on your own devices, and in your own private AI account.

Chuck Kinney

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AI can make mistakes — always double-check.

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How It Works

Most people have medical records scattered across patient portals, paper folders, email attachments, and phone photos. This guide shows you how to put all of them in one private Google Drive folder, hand them to an AI assistant, and have it fill in every tab of the **New Patient Provider Clinical Record Template** — labs, visits, hospital stays, imaging, procedures, medications, immunizations, contacts, and more — with a source listed for every entry.

Step	What you do	Time
1. Gather	Download or request every record you can find	1–3 weeks (requests can take time)
2. Folder	Create one private Google Drive folder and drop everything in	20 minutes
3. Link	Copy a private (Restricted) link to the folder	2 minutes
4. Connect	Upload the files or connect Google Drive to your AI app	10–30 minutes
5. Prompt	Paste the Master Prompt and let the AI fill the workbook	30 minutes to a few hours
6. Check	Review every entry against the originals and save the workbook back to Drive	1–2 hours

You do not have to sort anything first.

Drop every file into one Inbox folder. The Master Prompt tells the AI to read every file, build a Source Index, and put each piece of information in the right tab. Sorting into subfolders is helpful, but optional.

Step 1 — Gather Every Record You Have

Under HIPAA, you have the right to see and get copies of your medical and billing records from your providers and health plans, and in most cases you can get them electronically when they are kept electronically ([HHS — Your Medical Records](#)). A provider normally has up to 30 days to respond and cannot deny you a copy because of an unpaid bill ([HHS — Get it. Check it. Use it.](#)).

- **Patient portals** (MyChart and others): download lab results, visit summaries, discharge summaries, imaging reports, immunization records, and medication lists as PDFs. Look for "Download my record," "Share my record," or "Visit records."
- **Records requests:** for hospitals, past doctors, and anything not in a portal, ask the medical-records (Health Information Management) department for a complete electronic copy. You can ask for a format such as PDF or Excel ([HHS FAQ on electronic formats](#)).
- **Paper records:** scan them with your phone's scanner app into PDF. One document per file; make sure every page is flat, bright, and readable.
- **Home monitoring:** export blood-pressure cuff logs, connected-scale weight history, and smartwatch ECG PDFs.
- **Everything else:** pharmacy printouts, vaccine cards, insurance cards (front and back), advance directive, and power-of-attorney copies.

Step 2 — Create Your Google Drive Folder

- 1 Open Google Drive on a computer and click **New → New folder**.
- 2 Name it: **Medical Records — [Full Name]**. One person per folder. If you manage records for a parent or spouse, give each person their own folder.
- 3 Inside it, create the subfolders below. At minimum, create **00_INBOX** and **01_CLINICAL RECORD WORKBOOK**.
- 4 Put a blank copy of the Clinical Record workbook in **01_CLINICAL RECORD WORKBOOK**.
- 5 Drag every record you gathered into **00_INBOX**, or into the matching subfolder if you prefer to sort.

Folder	What goes in it
00_INBOX — New Records	Anything not yet processed. Dump everything here first.
01_CLINICAL RECORD WORKBOOK	The blank template, the current completed workbook, and an Old Versions subfolder
02_LABS	Lab and blood-work reports, every date
03_OFFICE VISITS	Visit notes, after-visit summaries, telehealth and urgent care
04_HOSPITAL & ER	Admission records, ER visits, discharge summaries
05_IMAGING & TESTS	X-ray, CT, MRI, ultrasound, echo, stress test, EKG, sleep study reports
06_PROCEDURES & PATHOLOGY	Operative reports, scopes, biopsies, pathology reports
07_MEDICATIONS & ALLERGIES	Medication lists, pharmacy printouts, allergy documentation
08_IMMUNIZATIONS	Vaccine cards, state immunization registry printouts, titers
09_HOME MONITORING	Blood pressure, weight, and smartwatch ECG exports
10_INSURANCE & AUTHORITY	Copies of insurance cards, advance directive, healthcare POA, HIPAA releases
11_PROVIDERS & CONTACTS	Provider lists, referral letters, care-team contact info
99_ARCHIVE	Replaced or duplicate files. Archive instead of deleting.

Name files the same way every time

YYYY-MM-DD_Document-Type_Facility-or-Provider.pdf

Example: 2025-08-14_LabResults_DesertRegional.pdf · 2024-03-02_DischargeSummary_EisenhowerHealth.pdf

Keep these out of the folder.

Passwords, portal logins, PINs, full Social Security numbers, full bank or credit-card numbers, and account recovery codes. If a record shows your full SSN, cover it before scanning or uploading.

Step 3 — Create Your Google Drive Link

A Google Drive link points to your folder. Who can open it depends on the folder's **General access** setting. Google offers three levels: **Restricted** (only people you add can open it), **Anyone with the link** (anyone who has the link can open it without signing in), and **Public** ([Google Drive Help — Share files](#)). Anything you put inside the folder inherits the folder's sharing setting ([Google Drive Help — Share folders](#)).

To copy a private link

- 1 Right-click the **Medical Records — [Full Name]** folder and choose **Share**.
- 2 Under **General access**, make sure it says **Restricted**. If it does not, click the down arrow and select **Restricted** ([Google — Stop, limit, or change sharing](#)).
- 3 Click **Copy link**, then **Done**. Save the link at the top of your Update Log.

Never set a medical-records folder to "Anyone with the link."

With that setting, anyone who gets the link — from a forwarded email, a screenshot, or a shared chat — can open every record without signing in. AI apps do not need it either: when Google Drive is connected inside the app, the AI opens your folder through your own Google sign-in.

Sharing with a trusted family member

In the same Share box, type the person's email address, choose **Viewer** (they can open and read but not change files), and click **Send**. Use **Editor** only for someone who will help add records. Review this list at least twice a year and remove anyone who no longer needs access.

What the link is for

- Pasting into an AI app **that has Google Drive connected** (see Step 4, Path B) so it knows exactly which folder to read.
- Giving your healthcare proxy or a family member fast access in an emergency, after you have added them by email.
- Writing on your Emergency Life Binder document map so trusted people know where the digital copies live.

Step 4 — Get Your Records Into the AI

Before you start, create a **private Project** in your AI app named **Medical Records — [Full Name]**, one person per Project. Then choose one of three paths.

	Path A: Upload files	Path B: Connect Google Drive	Path C: Connect records directly
Best for	Most complete, most reliable result; works on most plans	Large folders you keep adding to	Pulling records from portals automatically
How	In Drive, right-click the folder → Download. Unzip it, then upload the files into your AI Project.	Connect Google Drive in the AI app, then paste your private folder link with the Google Drive Link Prompt.	Use the AI app's health-records feature (US only), then run the Master Prompt.
Watch for	Upload limits per Project. Upload in batches of 10–20 files if needed.	Some connectors read only certain file types; ask the AI to list every file it could not open.	May not include every document, scanned paper, or older records. Add those by upload.

Connecting Google Drive in each app

App	Where to connect	What to know
ChatGPT	Settings → Plugins or Apps → Google Drive → Connect, then sign in to Google (OpenAI Help)	Live access to files your Google account can already open (OpenAI Help).
Claude	Settings → Connectors → Google Drive; in a chat, click + → Add from Google Drive (Claude Help)	Can read Sheets, PDFs, images, and Microsoft Office files; asks your approval before sharing, moving, or deleting files (Claude Help).
Perplexity	Settings → Connectors → Google Drive → Enable → Add Connector; then use the three-dot menu → Upload to sync chosen files or folders (Perplexity Help)	Available on Pro, Max, Enterprise Pro, and Enterprise Max; supports PDFs, Office files, and Google Docs and Sheets (Perplexity Help).

Path C options: health-record connections

- ChatGPT Health** can connect Apple Health and supported US hospital-system records; open Health from the sidebar and select Get started ([OpenAI Help — Health in ChatGPT](#)). OpenAI says connected medical records and Health conversations are not used to improve its foundation models by default ([OpenAI Health Privacy Notice](#)).
- Claude + HealthEx** connects records from your providers through Settings → Connectors → HealthEx, with ID verification through CLEAR ([Claude tutorial](#)). It is available to US Claude Pro and Max users ([HealthEx](#)).

Availability and plan requirements change. Confirm what your plan includes inside the app.

Privacy Settings at a Glance

Check these before uploading any records.

Platform	Separate Projects	Turn off AI training / retention	Keep information separated
ChatGPT	New Project for each person	Settings → Data Controls → turn off "Improve the model for everyone" ¹	Project settings → Memory → Project-only memory ²
Claude	Separate Project for each person	Settings → Privacy → turn off the option to help improve Claude ³	Keep files and chats in that person's Project
Perplexity	Separate Space or Project for each person	Account Settings → Preferences → turn off AI data retention ⁴	Do not share threads or Spaces; confirm the Space is private

Setting names reflect each platform's help pages as of October 2026. Confirm current labels in the app.

1. [OpenAI — Data controls in ChatGPT](#) 2. [OpenAI — Projects in ChatGPT](#) 3. [Anthropic — Model improvement settings](#) 4. [Perplexity — Data collection](#)

Step 5 — Run the Master Prompt

- 1 Open the private Project. Upload the blank workbook **New Patient Provider Clinical Record Template.xlsx**.
- 2 Upload your records (Path A), or connect Google Drive (Path B), or connect health records (Path C).
- 3 Copy the Master Prompt (pages 9–12). Fill in the name, date of birth, and where the records are. Paste it and send.
- 4 The AI will first list every file it found (the Source Index). Check that the count matches your folder.
- 5 If the AI stops partway, reply **continue**. Large record sets often take several replies.
- 6 When asked about the two facility-specific tabs at the end of the workbook, tell the AI to rename them for your main hospitals or leave them blank.

Step 6 — Check It and Save It Back to Drive

- 1 Download the completed workbook. Spot-check at least 10 entries on every tab against the original file listed in its Source column.
- 2 Read every item on the **Data Quality** tab, especially anything marked HIGH, such as a possible wrong-patient record.
- 3 Save the workbook to **01_CLINICAL RECORD WORKBOOK** with the date in the file name. Move the previous version to Old Versions.
- 4 Move processed files out of 00_INBOX into their subfolders (or leave them; the Source Index tracks them).
- 5 After every new visit, lab, or hospital stay: add the new files to 00_INBOX and run the **Update Prompt** (page 13).

What the AI Fills In

The workbook has 25 tabs. The Master Prompt tells the AI exactly what goes in each one, and adds a Source Index tab so you can see every file it read.

Tab	What it holds
Patient Profile	Demographics, emergency contacts, diagnoses with ICD-10 codes, immediate medical alerts
Master Flowsheet	Every lab test by date, side by side, oldest to newest
Current Snapshot	Latest value of key tests with trend
Abnormal Trends	Results repeatedly out of range
Gap Analysis — Next Steps	Overdue follow-ups and questions to ask your care team
Pathology Timeline	Biopsy and pathology findings
Admissions	Hospital stays and ER visits
Outpatient Encounters	Office, clinic, telehealth, and urgent-care visits
Radiology & Diagnostics	Imaging and diagnostic test results
Special Procedures	Surgeries, scopes, biopsies, infusions
Medications & Allergies	Current and past medications, supplements, allergies
Immunizations & Prevention	Quick-view vaccine and immunity status
Follow-up & Surveillance	Every recheck and referral your providers ordered
Contacts	Emergency contacts, care team, pharmacies, labs
Insurance & Authority	Plans, advance directive, POA, HIPAA releases
Home Blood Pressure	Home cuff readings
Vitals	Vitals from visits and home
Weight	Weight history
ECG	Clinic EKGs and smartwatch ECGs
Immunizations & Injections	Itemized dose-by-dose history with lot numbers
Clinical Timeline	Major health events, oldest to newest
Data Quality	Conflicts, missing pages, unreadable files
Raw Data	Every individual lab result — the foundation
Two facility trend tabs	Rename for your main hospitals, or leave blank
Source Index (added by AI)	Every file read, with date, facility, and status

The Master Prompt

Copy everything inside the shaded box.

Replace the items in [brackets] with your information. A plain-text copy (Medical-Records-AI-Master-Prompt.txt) is included for easy copy and paste.

You are helping me build my own patient-maintained medical record. I have uploaded (or connected) my medical records and a blank Excel workbook named "New Patient Provider Clinical Record Template." Your job is to read EVERY record I have provided and fill in the workbook as completely and accurately as possible, using only what is written in my records.

PATIENT: [Full legal name] DATE OF BIRTH: [MM/DD/YYYY]

WHERE MY RECORDS ARE: [Uploaded to this Project] OR [Google Drive folder: "Medical Records — Full Name" — link: paste private link here]

PART 1 — GROUND RULES (FOLLOW THESE EVERY TIME)

1. Use only my records. Never guess, assume, invent, or "fill in typical values." If something is not in my records, leave the cell blank or write "Not found in records."
2. Cite every entry. For every row you add, record the source in that tab's Source / Evidence column as: File name, page number, document date, and facility. Example: "2024-03-14_LabResults_DesertRegional.pdf, p.2."
3. Mark how solid each entry is. Use one of these labels in the Evidence Status column (or at the start of the Source column if there is no Evidence Status column):
 - VERIFIED — taken directly from an original report, note, or result
 - SUMMARY — taken from a portal summary, after-visit summary, or letter, not the full report
 - PATIENT-REPORTED — information I told a provider, or that I typed in myself
 - UNCLEAR — hard to read, conflicting, or incomplete; needs my review
4. Copy exactly. Copy numbers, units, dates, medication names, doses, and reference ranges exactly as written. Do not round, convert units, or rename tests unless I ask. If you must standardize a test name to match a row, keep the original name in the Source note.
5. Do not diagnose or advise. Do not add diagnoses, interpretations, or treatment recommendations that are not in my records. You may summarize what a clinician wrote. In "Interpretation," "Clinical Significance," and "Gap Analysis" columns, write only what my records say or phrase items as "Question to ask my care team." Never tell me to start, stop, or change a medication.
6. ICD-10 codes. Enter an ICD-10-CM code only if it appears in my records. If no code appears, leave it blank.
7. Never delete or overwrite. Keep every tab, title, header, column, row label, color, and format in the workbook exactly as they are. Only add information. If a cell already has information that conflicts with a record, keep both and log the conflict on the Data Quality tab.
8. Restricted details. Do not enter full Social Security numbers, passwords, portal logins, PINs, or full bank/credit-card numbers. For insurance member IDs, use the last 4 digits only.
9. Sensitive records. If you find mental-health, substance-use, reproductive, HIV, or genetic information, include it accurately but flag the row "SENSITIVE" in the notes so I can decide what to keep in printed copies.
10. Be complete. Process every file, every page, and every date. Do not stop after a sample or say "and so on." If there is too much to finish in one reply, finish what you can, tell me exactly where you stopped (file name and page), and continue when I reply "continue."

PART 2 — STEP 1: BUILD A SOURCE INDEX FIRST

Before filling anything in, add ONE new tab at the end of the workbook named "Source Index" (do not change any existing tab). List every file you can see:

File Name	Document Date	Facility / Provider	Document Type (lab, visit note, discharge summary, imaging, pathology, procedure, medication list, immunization record, insurance, legal, home monitoring, other)	Pages	Processed? (Yes / Partly / No)	Notes
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Show me the count of files and the date range covered, then begin Step 2. If any file cannot be opened or read (blurry scan, password-protected, image you cannot read), list it as "No" and explain why.

PART 3 — STEP 2: FILL IN EVERY TAB

Fill the tabs in this order. Raw Data is the foundation — every lab number goes there first, and other lab tabs are built from it.

1. RAW DATA — One row for EVERY individual lab or test result from every report, every date.

Columns: Collection Date | Category | Test | Result | Units | Reference Range | Flag (H, L, Critical, Abnormal, or blank) | Source | Specimen.

Use the reference range printed on that lab report, not a range from memory.

2. MASTER FLOWSHEET — A side-by-side trend grid.

- Row 2: put each collection date in its own column, starting at column C, oldest on the left, newest on the right.
- Row 3 ("Location"): put the lab or facility for that date.
- Put each result in the row for that test, under its date. Add H or L after flagged values (example: 182 H).
- If a test is not already listed, add a new row inside the correct section (CBC, Metabolic, Lipids, Thyroid, etc.).
- The Reference column holds sample ranges. If my lab's range is different, keep the sample range in place and note my lab's range on the Data Quality tab.

3. CURRENT SNAPSHOT — For each test that has ever been abnormal or is commonly tracked (A1c, glucose, lipids, kidney function, liver tests, CBC, thyroid, vitamin D, PSA if applicable): Test | Latest Result | Units | Reference Range | Collection Date | Flag | Historical Comparison / Trend (example: "Up from 5.9 in 03/2024 to 6.4 in 08/2025").

4. ABNORMAL TRENDS — Any result that is repeatedly out of range or moving in one direction: Finding | Verified facts (dates and values) | Interpretation (only what a clinician wrote, otherwise "Not interpreted in records") | Risk / Follow-up (only what records say, or "Question to ask my care team") | Source.

5. PATIENT PROFILE — Demographics table (legal name, preferred name, DOB, sex, blood type, height, most recent weight with date, address, cell, organ donation, preferred hospital, preferred pharmacy, medical devices, advance directive status). Use the "Verification / Source" column for every field.

Then fill: Emergency / Authorized Contacts; Active / Relevant Diagnoses and ICD-10-CM (Diagnosis | ICD-10-CM | Date / Status | Key Context); Immediate Medical Alerts (severe allergies, blood thinners, implanted devices, seizure risk, difficult airway, DNR/POLST, and anything a clinician flagged as critical).

6. ADMISSIONS — Every hospital stay, observation stay, and emergency visit: Admission Date | Facility | Encounter Type | Stay (dates / length) | Reason / Principal Issue | Key Findings / Hospital Course | Disposition / Follow-up | Evidence Status / Source.

7. OUTPATIENT ENCOUNTERS — Every office, clinic, telehealth, urgent care, and specialist visit: Date | Facility / Service | Encounter Type | Reason / Conditions Addressed | Key Assessment / Plan | Evidence Status / Source.

8. RADIOLOGY & DIAGNOSTICS — X-rays, CT, MRI, ultrasound, echo, stress test, EKG, sleep study, PFTs, DEXA, etc.: Study Date | Study / Test | Facility | Key Findings | Impression / Clinical Result (copy the radiologist's or reader's impression) | Evidence Status / Source.

9. SPECIAL PROCEDURES — Surgeries, scopes, biopsies, catheterizations, injections, infusions: Date | Procedure | Type | Indication / Context | Result / Key Finding | Evidence Status / Source.

10. PATHOLOGY TIMELINE — Every pathology or cytology report: Date | Specimen / Study | Key Finding (copy the final diagnosis line) | Clinical Significance (only as stated) | Source.

11. MEDICATIONS & ALLERGIES — Category (Current, Past / Stopped, As Needed, Supplement, Allergy, Intolerance / Adverse Reaction) | Medication / Substance | Dose / Route (and frequency) | Status / Use (with start and stop dates if known, and prescriber) | Clinical Note (reason, reaction type, who documented it). Use the most recent medication list as "Current" and note the date of that list. If two records disagree, list both and log it on Data Quality.

12. IMMUNIZATIONS & INJECTIONS (itemized history) — Use these column headers in row 3 (replace "Column1" to "Column9"): Date | Vaccine / Injection | Product / Manufacturer | Lot Number | Dose / Series Number | Route / Site | Given By / Location | Next Dose Due (only if stated in records) | Source. Include long-acting injections (for example, B12, testosterone, depot medications) if they appear in my records.

13. IMMUNIZATIONS & PREVENTION (quick view) — Starting on row 3, use these headers: Vaccine or Immunity | Most Recent Date | Series Status (complete, partial, unknown) | Immunity Evidence (titer results, if any) | Next Due / Question to Ask | Source.

14. FOLLOW-UP & SURVEILLANCE — Every follow-up, repeat test, referral, or "recheck in X months" written in my records: Issue | Most Recent Evidence | Recommended / Pending Action (as written by the clinician) | Priority (High if marked urgent or overdue; otherwise Routine) | Status (Done, Pending, Overdue, Unknown) | Evidence Note.

15. GAP ANALYSIS — NEXT STEPS — Starting on row 3, use these headers: Area (Screening, Lab Monitoring, Immunization, Specialist Follow-up, Imaging, Dental/Vision/Hearing, Other) | Item | Last Done (date from records) | What My Records Say | Status (Up to date, Due, Overdue, No record found) | Question to Ask My Care Team | Priority | Source. Base this on follow-up instructions in my records. If you also refer to general published screening guidance (for example, USPSTF or CDC), name the guideline and its date, mark the row "GENERAL GUIDANCE — NOT FROM MY RECORDS," and phrase it as a question only.

16. CONTACTS — Emergency / Decision Contacts; Current Healthcare Providers (every provider and facility named in my records, with specialty, phone, and location if listed); Operational Contacts (pharmacy, labs, imaging centers, medical-equipment suppliers, insurance customer service).

17. INSURANCE & AUTHORITY — Starting on row 3, use these headers: Item | Details | Effective / Expiration Date | Source or Where the Original Is Kept. Include insurance plans (plan name, last 4 of member ID, group number, phone), Medicare / Medicaid, prescription plan, advance directive, healthcare power of attorney, HIPAA authorizations, POLST / DNR. Record that a legal document exists and where it is — do not rewrite or summarize its legal wording.

18. HOME BLOOD PRESSURE — Starting on row 3, use these headers: Date | Time | Systolic | Diastolic | Pulse | Notes / Device / Arm. Only if I provide home readings or a device export.

19. VITALS — Starting on row 3, use these headers: Date | Setting / Source (clinic, hospital, home) | Blood Pressure | Pulse | Temp / SpO2 / Respirations | Weight / BMI / Notes. Include vitals recorded at visits.

20. WEIGHT — Use these column headers in row 2 (replace "Column1" to "Column5"): Date | Weight | Units | BMI (if listed) | Source.

21. ECG — Starting on row 3, use these headers: Date / Time | Classification or Rhythm | Average Heart Rate | Symptoms Noted | Source / Notes. Include clinic EKGs and smartwatch ECG exports if provided.

22. CLINICAL TIMELINE — One row per major health event, oldest to newest (diagnoses, hospitalizations, surgeries, major imaging findings, new long-term medications, cancer or cardiac events). Do not list individual lab results here. Starting on row 3, use these headers: Date | Event | Category | Significance (as stated in records) | Source.

23. FACILITY LAB TREND TABS — The last two tabs are examples named for specific health systems ("Desert Regional Lab Trend" and "WellStar Admission Trend"). Ask me whether to (a) rename them for my two main hospitals or health systems and fill them using the same column headers, or (b) leave them blank. Do not delete them.

24. DATA QUALITY — Log every problem: Issue | Status (Open / Resolved) | Impact | Action / Note. Include: unreadable pages, missing pages, conflicting values or medication lists, name or date-of-birth mismatches (possible wrong-patient record — mark HIGH), duplicate reports, differing reference ranges, and gaps in years with no records.

PART 4 — STEP 3: CHECK YOUR WORK, THEN DELIVER

Before you give me the file:

1. Re-check every row against its source. Confirm names, dates, numbers, units, doses, and allergies.
2. Confirm every file in the Source Index is marked Processed = Yes, or explain why not.

3. Give me the completed workbook as a downloadable .xlsx file named:

[YYYY-MM-DD]_Clinical-Record_[FullName].xlsx

If you cannot create an Excel file, give me each tab as a table I can copy and paste, one tab at a time, using the exact column headers above.

4. Then give me a short summary (plain language, under 300 words):

- How many files and pages you read, and the date range covered
- How many rows you added to each tab
- Every item on the Data Quality tab marked HIGH
- The 5 most important "Questions to Ask My Care Team"
- Anything you could not read or were unsure about

End every reply with:

"AI can make mistakes. Please check every entry against your original records and review it with your healthcare provider before relying on it."

The Update Prompt

Use after new visits, labs, or hospital stays.

Paste this when you have new records to add later.

I have added new medical records to my folder (or uploaded them here), plus my most recent completed workbook "[file name].xlsx." Follow all the Ground Rules from the Master Prompt.

1. Add the new files to the Source Index and mark them processed.
2. Add the new information to every tab where it belongs. Add new dates as new columns on the Master Flowsheet (newest on the right).
3. Do not change or remove any existing entries. If new information conflicts with an older entry, keep both and log it on Data Quality.
4. Move medications that a new record shows as stopped to "Past / Stopped," with the stop date and source.
5. Update Current Snapshot, Follow-up & Surveillance, and Gap Analysis to reflect the newest results.
6. Give me the updated workbook named [YYYY-MM-DD]_Clinical-Record_[FullName].xlsx and a short list of what changed.

End with: "AI can make mistakes. Please check every entry against your original records."

The Google Drive Link Prompt

Use only after connecting Google Drive inside your AI app. Keep the folder set to Restricted.

Use this only if you connected Google Drive inside your AI app. Keep the folder set to "Restricted."

Using my connected Google Drive, open the folder at this link: [paste your private folder link]. Read every file in this folder and all of its subfolders, including PDFs, images, Word, Excel, and Google Docs and Sheets. List every file you were able to open and every file you could not open, then follow the Master Prompt above using these files as my records.

AI can make mistakes — always double-check.

Check every AI-filled entry against your original records and review it with your healthcare provider before relying on it. In an emergency, call 911.