Portable Medical Summary

Legal Name:		**Address:**
Home phone:		
Cell phone		
Email:		

INSURANCE	Company:	Certificate #	BC Plan / BS Plan Rx BIN
		Group #	Phone: 800- _ _ _ - _ _ _ _

Legal Health POA *	Name	Relationship	Cell phone	Home phone	Work phone

DOB _ _ / _ _ / _ _ _ _ **HEIGHT/WEIGHT**: _____ **ADVANCE DIRECTIVES:** YES / NO **DNR:** YES / NO
SS# _ _ _ - _ _ - _ _ _ _ **BLOOD TYPE**: _____ **ORGAN DONOR:** YES / NO

Pain threshold:
Patient **ALLERGIES:**

Patient preferences:

HEALTH ISSUES			
System		Health issue	Age at onset
	ICD-9 _ _ _		
	ICD-9 _ _ _		

MEDICATIONS		
	Name	To treat
Rx		
OTC		

MEDICAL HISTORY					
System		Diagnosis:	Age at onset:	Age of next episode:	Age of next episode:
	ICD9 - _ _ _				
	ICD9 – _ _ _				
	ICD9 - _ _ _				
	ICD9 – _ _ _				
	ICD9 - _ _ _				
	SURGERIES	Treatment (note if benign or cancer)			
	ICD9 - _ _ _				
	ICD9 - _ _ _				

MEDICAL TESTS			
	Month/Year	Results	Company / Address
Blood			
Other			

IMMUNIZATIONS						
	Tetanus	TB	Pneumococcal vaccine	Other:	Other:	Other:
Year						

FAMILY HISTORY			
	Alive/deceased	Age	Health Issues, Cause of Death
Father			
Mother			
Child			

PHYSICIANS			
	Name	Phone	Address
Primary Care			
Specialist			
Specialist			
Specialist			

OTHER			
	Name	Phone	Address
Dental			
Rx –Pharmacy			