**Take this sheet to every doctor's appointment**

# Portable Medical Summary

Name _____ Date updated____/__/____
Address_____
_____Email _____
Phone_____ Mobile_____ Other_____
DOB ____/__/____ SSN____-__-____ Allergies_____
_____

**Pertinent personal characteristics:**

What are you like when you **feel good**?_____
_____
What are you like when you **don't feel good**?_____
_____
What do you **like** when you go to the doctor?_____
_____
What do you **not like** when you go to doctor?_____
_____

**Primary Diagnosis** **Age:**

1. _____

2. _____

3. _____

| MEDICAL | | | |
|---|---|---|---|
| **Medications** | | **Medical providers** | |
| **Rx Daily** | **Rx Monthly** | **Primary Care Provider** | |
| | | **Dentist** | |
| | | **Ophthalmologist/ Optometrist** | |
| | | **Specialty Provider(s)** | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| **Rx PRN (take as needed)** | | **Herbs/Supplements** | **Immunizations** Please attach record |

# Take this sheet to every doctor's appointment

| Medical Equipment | Medical Supplies | Provider | Contact Info |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| Nutrition/Fitness Goals | Provider | Contact Info |
|---|---|---|
| | | |
| | | |

**Past Hospitalizations (including surgeries)**

| Date | Hospital Name | Reason | Physician |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| Functional Capabilities | Brief Summary |
|---|---|
| | |
| | |
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| | |

| Future Plans (including agencies involved & referrals made) |
|---|
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| |
| |
| |

| Services Currently Receiving | Provider Contact Information |
|---|---|
| | |
| | |
| | |
| | |

## HEALTH INSURANCE

| Primary | Contact | Secondary | Contact |
|---|---|---|---|
| | | | |

**HEALTH SURROGATE**
**Name** **hm.#** **wk.#** **cell #**

**Signature Youth/Guardian: _____ Date_____**

**Primary Care Provider: (My doctor I see the most) _____**

**Address: _____Phone: _____**