# PORTABLE MEDICAL SUMMARY NAME __-

_____

| NAME | BIRTH DATE |
|---|---|
| ADDRESS | PARENT/GUARDIAN |
| | |
| | HOME/WORK PHONE |
| PRIMARY LANGUAGE | EMERGENCY CONTACT |
| | |
| | PHONE NUMBER(S) |
| **PERTINENT PERSONAL CHARACTERISTICS** | |

| MEDICATIONS | | Allergies | REACTIONS |
|---|---|---|---|
| DAILY Rx | MONTHLY Rx | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| **Rx PRN** | | **HERBS/SUPPLEMENTS** | |
| **OXYGEN** YES____ NO_____ QUANTITY _____ | | | |
| **IMMUNIZATIONS UP TO DATE** YES_____ NO_____ | | **IMMUNIZATION RECORD (PLEASE ATTACH)** | |

| PRIMARY DIAGNOSIS | AGE AT TIME OF DIAGNOSIS |
|---|---|
| | |
| **OTHER DIAGNOSIS** | |
| | |
| | |

| Hospitalizations/Surgeries/Procedures | Date | Hospital Name | Physician |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| BASELINE VITALS | BASELINE NEUROLOGICAL STATUS |
|---|---|
| RESPIRATIONS_____ TEMP_____<br>O2_____ PULSE_____ BP_____/_____ | |

_____

| BASELINE FINDINGS |
|---|

| COMMON PRESENTING PROBLEMS | TREATMENT CONSIDERATIONS |
|---|---|
| 1. | 1. |
| 2. | 2. |

| PRIMARY CARE PHYSICIAN | EMERGENCY PHONE |
|---|---|
| | FAX |
| **OTHER PHYSICIAN** | **OTHER PHYSICIAN** |
| EMERGENCY PHONE<br>FAX | EMERGENCY PHONE<br>FAX |
| **OTHER PHYSICIAN** | **OTHER PHYSICIAN** |
| EMERGENCY PHONE<br>FAX | EMERGENCY PHONE<br>FAX |

| MEDICAL EQUIPMENT | MEDICAL SUPPLIES | PROVIDER | CONTACT INFO |
|---|---|---|---|
| | | | |
| | | | |
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| | | | |
| | | | |

| SERVICES CURRENTLY RECEIVING | PROVIDER CONTACT INFO |
|---|---|
| | |
| | |
| | |

| HEALTH INSURANCE PRIMARY | HEALTH INSURANCE SECONDARY |
|---|---|
| NAME | NAME |
| PHONE | PHONE |

| OTHER COMMENTS |
|---|
| |

Signature Parent/Guardian _____ Date _____

Signature Primary Care Provider_____Phone _____