



Take a copy of this form with you to any appointment with a health care provider, especially if going to the emergency room, a specialist, or the hospital.

HEALTH SUMMARY

Name: _____

Birth date: _____ SS: _____

Address: _____

Significant other: _____
Name and Address

Durable power of attorney for health care and living will. _____
List Who Has This Responsibility

Primary Care Provider: _____
Name, Address, Phone, and Emergency Number

Health Insurance: _____

Dental Insurance: _____

Prescriptions: _____
Pharmacy

Medications taken daily: _____
Include Prescriptions and Nonprescriptions (vitamins, herbs etc.) Drugs

Medications with adverse reactions: _____

Allergies: _____

Immunizations: _____

Recent medical care: (List Medical Care Chronologically For Past Few Years)

- _____
- _____
- _____
- _____

Medical history including surgery: (List By Date)

- _____
- _____
- _____
- _____

Mental health history and recent stressors: _____

Family history: (List Health Problems Of Family Members Starting With Your Parents)

- _____
- _____