**Allergies:**

* **Drug 1**
* **Drug 2**
* **Drug 3**
* **Metal**
* **Food**

**Diagnoses:**

* Physical
  + Diagnosis 1
  + Diagnosis 2
  + Diagnosis 3
  + Diagnosis 4
  + Diagnosis 5
  + Diagnosis 6
  + Diagnosis 7
  + Diagnosis 8
  + Diagnosis 9
  + Diagnosis 10
  + Diagnosis 11
  + Diagnosis 12
  + Diagnosis 13
  + Diagnosis 14
  + Diagnosis 15
* Mental
  + Diagnosis 1
  + Diagnosis 2
  + Diagnosis 3
  + Diagnosis 4
  + Diagnosis 5
  + Diagnosis 6

**Immunizations:** Flu – [mm/dd/yyyy]

Pneumonia – [mm/dd/yyyy]

Tetanus, Diptheria, and Pertussis – [mm/dd/yyyy]

**Current HbA1c: [# and date]**

**Blood Type:** [type]

**Eyes:**  Contacts/Glasses

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**Medications:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Medication** | **Dose** | **Purpose/Notes** |
| ***Morning*** |  |  |  |
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| ***Evening*** |  |  |  |
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**Medicine Contraindications (NOT allergic):**

* [drug – reason]
* [drug – reason]

**Other Social Determinants of Health:**

* Marital Status: [single, married, divorced]
* Living arrangements: [home/apartment/roommates]
* Pregnant: [never/yes/previously, and relevant info]
* Birth Control: [if applicable]
* History of abuse: [Verbal/emotional, physical, sexual]
* Occupation: [relevant info]
* Religious Preference: [relevant info]
* Substance use:
  + Alcohol: [usage]
  + Drugs: [usage]
  + Tobacco: [usage]
* Education [if relevant]:
* Previous work history [provided for context] (personally I provide as to knowledge of health, healthcare systems, law and policy]
  + [position or work area]
* Hobbies:
  + Hobby 1
  + Hobby 2
  + Hobby 3
  + Hobby 4
  + Hobby 5

**Other Medical Documentation:**

* Out of Hospital Do Not Resuscitate Order
* Directive to Physicians and Family or Surrogates
* Notice to Person Making a Declaration for Mental Health Treatment
* Anatomical Gift to the Anatomical Board [place]
* Lab and test results 2002-present
* Medical records 2002-present
* Assorted journal articles and research

**Surgeries:**

[Date of Surgery] Surgery 1

[Date of Surgery] Surgery 2

[Date of Surgery] Surgery 3

[Date of Surgery] Surgery 4

[Date of Surgery] Surgery 5

[Date of Surgery] Surgery 6

**Hospitalizations/Procedures:**

[Date of Hospitalization/Procedure] Hospitalization/Procedure 1

[Date of Hospitalization/Procedure] Hospitalization/Procedure 2

[Date of Hospitalization/Procedure] Hospitalization/Procedure 3

[Date of Hospitalization/Procedure] Hospitalization/Procedure 4

[Date of Hospitalization/Procedure] Hospitalization/Procedure 5

[Date of Hospitalization/Procedure] Hospitalization/Procedure 6

[Date of Hospitalization/Procedure] Hospitalization/Procedure 7

[Date of Hospitalization/Procedure] Hospitalization/Procedure 8

[Date of Hospitalization/Procedure] Hospitalization/Procedure 9

[Date of Hospitalization/Procedure] Hospitalization/Procedure 10

[Date of Hospitalization/Procedure] Hospitalization/Procedure 11

[Date of Hospitalization/Procedure] Hospitalization/Procedure 12

[Date of Hospitalization/Procedure] Hospitalization/Procedure 13

[Date of Hospitalization/Procedure] Hospitalization/Procedure 14

[Date of Hospitalization/Procedure] Hospitalization/Procedure 15

[Date of Hospitalization/Procedure] Hospitalization/Procedure 16

[Date of Hospitalization/Procedure] Hospitalization/Procedure 17

[Date of Hospitalization/Procedure] Hospitalization/Procedure 18

[Date of Hospitalization/Procedure] Hospitalization/Procedure 19

[Date of Hospitalization/Procedure] Hospitalization/Procedure 20

[Date of Hospitalization/Procedure] Hospitalization/Procedure 21

[Date of Hospitalization/Procedure] Hospitalization/Procedure 22

[Date of Hospitalization/Procedure] Hospitalization/Procedure 23

[Date of Hospitalization/Procedure] Hospitalization/Procedure 24

[Date of Hospitalization/Procedure] Hospitalization/Procedure 25

**Onset of Diagnoses [including resolved diagnoses like broken bones]:**

[Date of Diagnosis] Diagnosis 1

[Date of Diagnosis] Diagnosis 2

[Date of Diagnosis] Diagnosis 3

[Date of Diagnosis] Diagnosis 4

[Date of Diagnosis] Diagnosis 5

[Date of Diagnosis] Diagnosis 6

[Date of Diagnosis] Diagnosis 7

[Date of Diagnosis] Diagnosis 8

[Date of Diagnosis] Diagnosis 9

[Date of Diagnosis] Diagnosis 10

[Date of Diagnosis] Diagnosis 11

[Date of Diagnosis] Diagnosis 12

[Date of Diagnosis] Diagnosis 13

[Date of Diagnosis] Diagnosis 14

[Date of Diagnosis] Diagnosis 15

[Date of Diagnosis] Diagnosis 16

[Date of Diagnosis] Diagnosis 17

[Date of Diagnosis] Diagnosis 18

[Date of Diagnosis] Diagnosis 19

[Date of Diagnosis] Diagnosis 20

[Date of Diagnosis] Diagnosis 21

[Date of Diagnosis] Diagnosis 22

[Date of Diagnosis] Diagnosis 23

[Date of Diagnosis] Diagnosis 24

[Date of Diagnosis] Diagnosis 25

[Date of Diagnosis] Diagnosis 26

[Date of Diagnosis] Diagnosis 27

[Date of Diagnosis] Diagnosis 28

[Date of Diagnosis] Diagnosis 29

[Date of Diagnosis] Diagnosis 30

**Possible Diagnoses (no formal diagnoses)**

* Diagnosis (physician suspected [date])

**Family Medical History**

Mother (DOB year – still living or age at death):

* + Diagnosis 1
  + Diagnosis 2
  + Diagnosis 3
  + Diagnosis 4

Maternal Grandfather (DOB year – still living or age at death):

* + Diagnosis 1
  + Diagnosis 2
  + Diagnosis 3
  + Diagnosis 4

Maternal Grandmother (DOB year – still living or age at death):

* + Diagnosis 1
  + Diagnosis 2
  + Diagnosis 3
* Diagnosis 4

Father (DOB year – still living or age at death):

* + Diagnosis 1
  + Diagnosis 2
  + Diagnosis 3
* Diagnosis 4

Fraternal Grandfather (DOB year – still living or age at death):

* + Diagnosis 1
  + Diagnosis 2
  + Diagnosis 3
* Diagnosis 4

Fraternal Grandmother (DOB year – still living or age at death):

* + Diagnosis 1
  + Diagnosis 2
  + Diagnosis 3
  + Diagnosis 4

Sibling (DOB year – still living or age at death):

* + Diagnosis 1

**Suicide attempts:**

Date Description Hospitalized?  
[Date of attempt] [method] [Yes/No] [medical and/or psych]

[Date of attempt] [method] [Yes/No] [medical and/or psych]

[Date of attempt] [method] [Yes/No] [medical and/or psych]

**Psychiatric Hospitalizations:**

Date Reason Location Voluntary?

[Date] [Reason] [City, State] [Yes/No]

[Date] [Reason] [City, State] [Yes/No]

[Date] [Reason] [City, State] [Yes/No]

[Date] [Reason] [City, State] [Yes/No]

[Date] [Reason] [City, State] [Yes/No]

**See also:** Attached email from [therapist]

**History of Psychiatric Medications (incomplete – do not have all records)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date First Noted in Records** | **Drug** | **Amount 1** | **Date 2** | **Amount 2** | **Notes** |
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**ECG Results**

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| --- | --- | --- |
| **Date** | **Reason ECG Done** | **Results** |
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**Pain Medications Contraindicated/Allergy**

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| --- | --- | --- |
| **Drug** | **Contraindicated/Allergic** | **Reaction** |
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**Other Pain Medications Tried:**

|  |  |  |
| --- | --- | --- |
| **Drug** | **Effective (Y/N)** | **Effects** |
|  |  |  |
|  |  |  |

**Pain Medications Tolerated:**

|  |  |  |
| --- | --- | --- |
| **Drug** | **Method of Administration** | **Effectiveness** |
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**Current Providers:**

* Primary Care Provider: Name, Practice Name

Phone:

Fax:

Last appointment:

Next appointment:

* Therapist Name, Practice Name

Phone:

Fax:

Last appointment:

Next appointment:

* Dentist Name, Practice Name

Phone:

Fax:

Last appointment:

Next appointment:

* Dermatologist: Name, Practice Name

Phone:

Fax:

Last appointment:

Next appointment:

* Endocrinologist Name, Practice Name

Phone:

Fax:

Last appointment:

Next appointment:

* Gastroenterologist Name, Practice Name

Phone:

Fax:

Last appointment:

Next appointment:

* Neurologist Name, Practice Name

Phone:

Fax:

Last appointment:

Next appointment:

* Neurologist (Headaches) Name, Practice Name

Phone:

Fax:

Last appointment:

Next appointment:

* OB/GYN Name, Practice Name

Phone:

Fax:

Last appointment:

Next appointment:

* Occupational Therapist Name, Practice Name

Phone:

Fax:

Last appointment:

Next appointment:

* Ophthalmologist: Name, Practice Name

Phone:

Fax:

Last appointment:

Next appointment:

* Optometrist Name, Practice Name

Phone:

Fax:

Last appointment:

Next appointment:

* Pain Management Name, Practice Name

Phone:

Fax:

Last appointment:

Next appointment:

* Physical Therapy Name, Practice Name

Phone:

Fax:

Last appointment:

Next appointment:

* Podiatrist Name, Practice Name

Phone:

Fax:

Last appointment:

Next appointment:

* Psychiatrist Name, Practice Name

Phone:

Fax:

Last appointment:

Next appointment:

* Rheumatologist Name, Practice Name

Phone:

Fax:

Last appointment:

Next appointment:

* Surgeon for herniated disc: Name, Practice Name

Phone:

Fax:

Last appointment:

Next appointment:

* Pharmacy: Pharmacy Name

Pharmacy Location/Address

Phone:

* Insurance Information: Insurance Name (Insurance Phone)