PERSONAL MEDICAL SUMMARY

Date completed :

File of Life

BASIC INFORMATION						
Name:				Phone:		Sex M F
Address:				City:		State:
Date of birth:			SSN#	Blood Type:		
Religion:			Local Clergy:		Church Phone:	
Advance Directive?	Y	N	Where filed?			
POLST?	Y	N	Where filed?			
Doctor:				Phone:		
Doctor:				Phone:		
Pharmacy:				Phone:		

EMERGENCY CONTACTS			
Name:		Address:	
	Home Phone:	Work Phone:	Cell Phone:
Name:		Address:	
	Home Phone:	Work Phone:	Cell Phone:
Name:		Address:	
	Home Phone:	Work Phone:	Cell Phone:

CURRENT MEDICAL CONDITIONS	
Condition:	Since when?
Condition:	Since when?
Condition:	Since when?
Condition:	Since when?

PAST MEDICAL CONDITIONS	
Condition:	When?
Condition:	When?
Condition:	When?
Condition:	When?

RECENT SURGERY		
Surgery Type:	Hospital:	Date:
Surgery Type:	Hospital:	Date:

Medications, Over-the-Counter Drugs, Herbs, Supplements

Drug:	Dose:	Frequency:

Other:	Dose:	Frequency:

Vision Impairment? N Y Describe: _____

Hearing Impairment? N Y Describe: _____

Other Impairment/Disability? N Y Describe: _____

Allergies? N Y To what? _____

Other important information:

MEDICAL INSURANCE	
Insurance Co:	Policy #:
Group #:	Phone:
Secondary Policy:	
Medicaid #:	Medicare #: