My Portable Medical Summary

Name:	Birth Date:
Address:	Parent/Guardian:
Primary Language:	Home/Work Phone:
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(es):	

Hospitalizations/Surgeries/Procedures	Date	Hospital Name	Physician

Baseline Vitals	Baseline Neurological Status
Respirations_____ Temp_____ O2_____ Pulse_____ Bp_____/_____	
Baseline Findings:	

Common Presenting Problems	Treatment Considerations
1.	1.
2.	2.

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Primary Care Physician:	Emergency Phone: Fax:
Other Physician:	**Other Physician:**
Emergency Phone: Fax:	Emergency Phone: Fax:
Other Physician:	**Other Physician:**
Emergency Phone: Fax:	Emergency Phone: Fax:

Medical Equipment	Medical Supplies	Provider	Contact Info

Nutrition/Fitness Goals	Provider	Contact Info

Functional Capabilities (brief summary)	**Future Plans** (agencies Involved/referrals made)

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:_____