**Medical Summary** Date: \_\_\_\_\_\_\_\_\_\_\_\_

 **Full Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Birthdate**: \_\_\_\_\_\_\_\_\_\_\_\_

BC Care #\_\_\_\_\_\_\_\_\_\_\_\_\_\_Extended Health \_\_\_\_\_\_\_\_\_\_#\_\_\_\_\_\_\_\_Travel Insurance \_\_\_\_\_\_\_ #\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: (*relationship, name, phone*)

Primary Care doctor: (*name, location, phone #)* Specialists: (*specialty,* *name, location, phone #)*

 ***ATTENTION!***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication issues?** *(reactions, allergies)*

**Medical Condition: Medications:**  name, dosage, prescribed by, notes
*Example: High blood pressure (dx 2010)* ***Perindopril*** *4mg. 1/day (Dr. Jones, since 2016)*

**Vitamins, minerals, etc.**

**Immunizations**: *(date)* Annual Flu shot \_\_\_\_\_\_\_\_\_\_\_\_ Covid 19 \_\_\_\_\_\_\_\_\_\_\_\_

Tetanus\_\_\_\_\_\_\_\_\_\_\_\_ Pneumovax \_\_\_\_\_\_\_\_\_\_\_\_ Shingles \_\_\_\_\_\_\_\_\_\_\_\_

**Surgeries:** *Year / surgery for / outcome or issues*