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:

Example: High blood pressure (dx 2010)

Medications: name, dosage, prescribed by, notes

***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*