

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*