A One-Page Medical Summary **Date:**

Name:
DOB:
Mobile:
Address:
City, State, Zip:
Email Address:
Insurance:
List insurance company (ies) with ID numbers

Emergency Contacts: *List with contact info*

Primary Care Physician: *Name, phone*
List all providers, specialty, phone number

Chief Complaint:
The reason for the visit, symptoms first, what you observe.

Illnesses/Conditions:

Condition	*Physician*	*ICD-10*	*Onset*	*Status*	*Treatment*

Immunizations:

Vaccine	*Date*	*Adverse Reactions*

Allergies:

Medications:

Medication	*Year started*	*Dose*	*For*	*Schedule*

Pharmacy:
List with phone number

Surgeries and Procedures:

Procedure	*Date*	*Surgeon*	*CPT*	*Outcome*

Subjective Mental Status:

Any recent changes in memory, perception or interpretation. Any recent anxiety or depression. Any recent changes in behavioral control, gait or balance. Any suicidal thoughts of actions. Any abuse.