

Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Patient Number: \_\_\_\_\_

# Medical Summary

## Major Medical Problems

Date	Description/Severity

## Continuing Medications

Date Prescribed	Date Discontinued	Medication and dosage

## Hospitalization/Surgery/Injury

Date	Problem/Diagnosis

## Allergies/Sensitivities

Date	Description/Severity