**Medical History Summary for Patient Name (Date of Birth), City, State**

Primary Care: Dr. Name, Phone #
Pharmacy: Name, Phone #

**Diagnoses**

* Enter in order of most recent diagnosis first—include month and year of diagnosis

|  |  |
| --- | --- |
| **Medications and Supplements*** Rx Name and amount (what diagnosis does this address), # of pills, frequency: for example, 2 pills every morning.
 | **Allergies/Adverse Reactions*** Rx and symptoms
* Food and symptoms
 |

**Family History**

* Note diagnoses of immediate family members. Be sure to include if deceased and their age.

**Procedures/Medical History**

* Note tests, results and date performed in order of most recent listed first.

**Surgeries**

* Note type of surgery, date formed in order of most recent listed first.

**Other Providers**

|  |  |  |
| --- | --- | --- |
| Specialty | Physician/Practice | Phone # |
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