

SUMMARY OF CARE

Please list all medications you are currently taking: (or provide a list)

Medication	Dose	How often?	Illnesses
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergy to Medication	What was the reaction?
_____	_____
_____	_____
_____	_____
_____	_____

Date of last Chest X-ray?

Date of last EKG?

Date of last Bone Density?

Date of last Colonoscopy?

What Surgeries have you had?

Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient: _____ Acct#: _____ D.O.B. _____