**EMERGENCY HEALTH SUMMARY DOCUMENT**

**Your Information:**

First Name: Type your First Name.

Middle Initial: Type your Middle Initial.

Last Name: Type your Last Name.

Date of Birth: Type your Date of Birth.

Address: Type your Address.

City: Type your City.

State: Type your State.

Zip Code: Type your Zip Code.

Home Phone: Type your Home Phone.

Mobile Phone: Type your Mobile Phone.

Work Phone/Ext: Type your Work Phone and/or Extension.

Allergies: Write down your Allergies.

Major Ailments: Write down your major ailments.

**Insurance Information:**

1. Insurance Name: Type your Insurance Name.

Policy Number: Type your Insurance Policy Number.

Group Number: Type your Insurance Group Number.

Phone: Type your phone.

Subscriber Name: Type Subscriber Name

Date of Birth: Type Subscriber Date of Birth.

Relationship: Type Subscriber Relationship

**Doctor’s Information:**

1. Doctor’s Name: Type your Doctor’s Name.

Doctor’s Speciality: Type your Doctor’s Speciality.

Address: Type your Doctor’s Address.

City: City

State: State

Zip Code: Zip Code

1. *Phone: Type your Doctor’s phone.*

Fax: Type your Doctor’s Fax.

Email Address: Type your Doctor’s Email Address.

**Medical Personnel/Nurse Information:**

1. Medical Personnel/Nurse Name: Type your Nurse/Medical Personnel Name.

Medical Personnel/Nurse Speciality: Type your Nurse/Medical Personnel Speciality.

Address: Address

City: City

State: State

Zip: Zip Code

1. *Phone: Phone*

Fax: Fax

Email Address: Email Address

**Hospital Admission History:**

1. Hospital Admission: Choose an item from drop down menu.

Hospital Admission Reason: Write down the reason you were admitted into hospital.

Admitted Date: Click or tap to enter Hospital Admitted date.

Release Date: Click or tap to enter Hospital Released date

Surgery Hospital/Center with City, State: If applicable, write down the place of your Surgical Procedure.

Surgery Performed By: If applicable, write down the name of your Surgery Doctor who performed procedure.

1. *Infection: If applicable, write down any Infections that you had after Hospital Visit.*

Notes: Any other useful information that you think can help Doctors.

**Prescription History:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Prescription Name | Dose(g/mg) | Number of Tablets | Frequency | Date Started | Date Ended |
| 1. Type your Prescription Name. | Type your dose. | Choose a value from drop down menu. | Choose a value from drop down menu. | Click or tap to enter a date. | Click or tap to enter a date. |