



Child's Name: _____

Date of Birth: _____

TAKE THIS SHEET TO EVERY DOCTOR'S APPOINTMENT

Portable Medical Summary

Name: _____ Date Updated: ____/____/____

Address: _____

Phone: _____ Mobile: _____ E-mail: _____

DOB: _____ SSN: _____ - _____ - _____ Allergies: _____

Pertinent Personal Characteristics:

What are you like when you **feel good**? _____

What are you like when you **don't feel good**? _____

What do you **like** when you go to the doctor? _____

What do you **not like** when you go to the doctor? _____

Primary Diagnosis _____ **Age:** _____

1. _____
2. _____
3. _____

MEDICAL			
Medications		Medical Providers	
Rx Daily	Rx Monthly	Primary Care Provider	Name
Rx PRN (take as needed):		Herbs/supplements:	Immunizations Please attach record





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Medical Equipment	Medical Supplies	Provider	Contact Info
Nutrition/Fitness Goals	Provider		Contact Info
Past Hospitalizations (including surgeries)			
Date	Hospital Name	Reason	Physician
Functional Capabilities		Brief Summary	
Future Plans (including agencies involved & referrals made)			
Services Currently Receiving		Provider Contact Info	
HEALTH INSURANCE			
Primary:	Contact:	Secondary	Contact:
Health Surrogate			
Name:	Home #	Work #	Cell #

Signature Youth/Guardian: _____ Date: _____

Primary Care Provider: (My doctor I see the most) _____

Address: _____ Phone: _____





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FAMILY HEALTH HISTORY

Biological Mother Pregnancy

Normal

Problems: _____

Type of Delivery: _____

Immediate Complications: _____

List any conditions or illnesses of child's close blood relatives (e.g. parents, brothers, sisters, uncles, aunts, grandparents):

Condition/Illness:	Family Member(s):	Comments:
Alcoholism/drug abuse or addiction		
Allergies		
Asthma		
Birth Defects		
Cancer		
Deafness		
Developmental Disabilities		
Diabetes		
Heart Disease		
HIV		
Kidney Disease		
Seizures / Epilepsy		
Sickle Cell		
Other Genetic Conditions		





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DOCTOR'S VISIT

Name: _____ DOB: _____ Date: _____

Existing Conditions/Diagnoses: _____

Visit's Purpose: [] Physical Sick Visit [] Sports/camp [] Immunization [] Other _____

* PARENTS SECTION *

PROBLEMS TO TALK ABOUT TODAY:

- _____
- _____
- _____

MEDICATIONS AND DOSAGES:

- _____
- _____
- _____

* HEALTH CARE PROVIDERS SECTION *

PROBLEM REVIEW:

- _____
- _____
- _____

* PHYSICAL EXAM *

Condition	Gen.	E.N.T.	Neck	Lungs	Heart	Abdom.	Mus./Skel/	Neuro	Skin

Abnormality explanation: _____

Height: _____ Weight: _____ BP: _____ HR: _____ Temp: _____

Medical Changes: _____

Testing Dates: _____

Location: _____

Next CP: _____ Vaccines due: _____ Flu Shot: [] Yes [] No Due?: _____

Doctor's Signature: _____





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RELEASE OF INFORMATION FORM

Name of Child: _____ Date of Birth: __/__/__

Address: _____

City: _____ State: _____ Zip: _____

I, _____ hereby authorize _____

print name of Parent/Guardian*

(person)

of _____

(name of doctor's office, school, other)

to obtain the following information about the above-named child:

(Check all that apply)

all medical records currently on file at _____ .

only the following medical records _____

currently on file at _____ .





Child's Name: _____
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[] In addition, I authorize

(1) _____ to release information concerning
the above named child to: _____

(2) _____ to release information concerning
the above named child to: _____

This authorization will automatically terminate on _____ unless previously revoked or extended by me, the undersigned.

Signature of Parent/Guardian* date

____ I hereby revoke this authorization _____
Signature of Parent/Guardian* date

____ I hereby extend this authorization for ____ months _____
Signature of Parent/Guardian* date

*If the patient is over ____ years of age, he or she may sign in place of parent/guardian.

Adapted from the aap

