LVP Portable Medical Summary

Patient Information

Legal Name: ____________________

Preferred Name: ____________________

Cell Phone: ____________________

Email: ____________________

Permanent Address: ____________________

Temporary Address: ____________________

Emergency Contact Name: ____________________

EC Phone: ____________ EC Email: ____________________

Problem List

Are there any health problems that your new provider should know?

Health Problem	Date of Diagnosis	Notes/Medications

Allergies

Drug/Allergen	Severity	Reaction

Medications

Medication	Dose	Frequency	What is it treating?

Preferred Pharmacy

Name	Phone	Address

Medical and Surgical History

- ☐ Unknown
- ☐ N/A

Procedure	Date

Family History (1st Degree Relatives)

☐ Unknown

Condition	Relation	Notes
Allergies		
Anemia		
Asthma		
Autoimmune Disorder		
Blood Disorder		
Cancer		
Diabetes		
GI Disorder		
Heart Disease		
Hypertension		
Lipid Disorder		
Mental Health Disorder		
Obesity		
Stroke		
Other: _______________		
Other: _______________		
Other: _______________		

Care Team Contacts

Provider Name	What is their specialty?	Phone Number
	Primary Care Provider	

Health Maintenance

What vaccines are you due for next?

Vaccine(s)	Date Needed

Upcoming appointments:

Appointment Type	Reason for Appt.	Provider/Location

Specialty Comments

Is there anything important that you would like your new doctor to know?

What questions would you like to ask your new primary care provider (PCP)?