MEDICAL SUMMARY

Name: ____

Birth Date: ____

Acute Problems

Health Problems	Date of Onset

Mental Health Problems	Date of Onset

Medication Allergies:

___ No Known Allergies

Medication/Substance	Type of Reaction

Medication (Please indicate all medications—Psychiatric and Non-Psychiatric)

Name	Dose	Start Date	Prescribing Doctor	Doctor's Phone

Surgical Procedures

Procedure	Date

Clinician: Date: