IAMNURSE

eLife Portable Patient Health Summary

Name:_____

Last **First** **Middle**

Date of Birth: ____/____/_____ **Gender: Male Female Transgender** **Weight: _____ lbs** **Height _____**

Blood Type _____

A-	**A+**	**B-**	**B+**	**AB-**	**AB+**	**O-**	**O+**

Special Diet: _____

Who is your primary care physician: _____ Contact number_____

Allergies: (*Food Medication, environmental other)*

Type of Allergy	What happens when you are exposed	Treatment

Health Screenings

Type	Date	Findings
Mammogram		
Colonoscopy		
Pap Smear		
Sonograms		
Flu Shot		
Pneumonia Vaccine		
Hepatitis		

Do you smoke?
YES/NO
Number per day____

Do you drink alcohol?
YES/NO
Weekly amount_____

Do you take recreational drugs?
YES/NO
Type_____ Amount

Last hospitalization: Date_____ Hospital_____ Reason_____

Medical Conditions or Injuries Currently Being Treated

Condition	Date of Onset	Treatment	Treating Physician

Current Prescription Medications (Giving by your Doctor)

Medication	Dose	Frequency	Reason for Taking	Prescribing MD

Other NON-Prescription Medications (Over the Counter)

Medications	Dose	Frequency	Reason for taking

Emergency Contacts

Name	Relationship to Individual	Mobile Phone #	Home Phone #	Work Phone #

Other Necessary Information/Special Needs

The Information contained her is accurate as of Today, _____/_____/2017

Form Completed by: _____

Name **Relationship to Patient**