

Kids First Pediatrics 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

