Date Completed:

My Medical Summary

Full Name: Preferred Name:
Sex: Gender:
Date of Birth:

Emergency Contact: Phone:

Medicare Card No.			
Individual Reference #		Expiry	
Health Insurance Fund		Member No.	

Medical History		
Condition	History	Treating Dr.

Allergies (include severity and where to find action plans if needed)

Medications (include herbs and supplements)		
Medication	When and How Much?	Used For

Family History		
Relationship	Sex	Medical Condition/s (include age of onset if known)

Other Notes (e.g. your values and preferences for care, recent screening test dates, where to find your Advance Care Plan)

General Practitioner
Name:
Practice:
Contact Details:

Specialist 1
Name:
Specialty type (e.g. Psychiatrist):
Practice:
Contact Details:

Specialist 2
Name:
Specialty type:
Practice:
Contact Details:

Specialist 3
Name:
Specialty type:
Practice:
Contact Details:

Dentist
Name:
Practice:
Contact Details:

Preferred Pharmacy
Name:
Address:
Contact Details: