HealthSum
We've Got Your Story

Personal Information Profile

First and Second Names: Family Name:

Date of Birth:

Address: City:

State/Province: ZIP/Postal Code: Country:

Telephone: Email:

Medical Information

Code Status: Other Code:

Canada Only:

Provincial Healthcare #: Province:

Name on Healthcare Account: Blood Type: Birth Gender:

Additional Healthcare Coverage Company: Name on Plan: Policy Number: Group Plan/Member Number:

US Only:

Medicare #: Coverage: Part A ◯ Part B ◯ Part C ◯ Part D ◯

Name on Healthcare Account: Blood Type: Birth Gender:

Additional Healthcare Coverage Company: Name on Plan: Policy Number: Group Plan/Member Number:

Emergency Contact Information

Name:

Address: City:

State/Province: Email:

Phone: Work Phone, extension:

Primary Care Physicians

Name: Dr. Specialty:

Address:

City: State/Province:

Office Phone: Email:

Medical Conditions

Condition: Onset/End: Diagnosis/Outcome: Current/Past:

Supplements

Supplement Name:	Date Started:	Remarks:

Medications

Medication:	Dosage:	Condition:	Remarks:

Allergies

Allergy:	Reaction:	Remarks:

Surgeries

Operations:	Date:	Remarks:

Immunizations

Name of Shot:	Date:	Remarks:

Family Medical History

Relationship:	Condition:	Date:	Remarks:

Legal Documents

Type of Document:	Held by:	Telephone:	Email: