# MEDICAL HISTORY

Hydrocephalus Association

## Personal Information

Name ______________________

Date of Birth ______________________

Phone Number ______________________

**Emergency Contact**

Name ______________________

Relationship ______________________

Phone Number ______________________

**Neurosurgeon**

Name ______________________

Hospital ______________________

Phone Number ______________________

**Pharmacy**

Pharmacist ______________________

Phone Number ______________________

## How to Use This Guide

- Save this document.
- Edit the copy on your computer to keep track of your medications (including prescription drugs, over-the-counter drugs, herbal supplements, and vitamins.)
- Keep a printed copy always with you.

*You should review this record when*

- Starting or stopping a new medicine.
- Changing a dose.
- Visiting your doctor

Last Updated: ______________________

## Other Physicians

**Primary Care Physician** ______________________

Hospital ______________________

Phone Number ______________________

**Neurologist**

Hospital ______________________

Phone Number ______________________

**Other Physician**

Specialty ______________________

Phone Number ______________________

## Allergies and Reactions

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## Medical Conditions

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# MEDICAL HISTORY

Hydrocephalus Association

## Hydrocephalus Related Surgeries

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## Non-hydrocephalus Related Surgeries

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## Miscellaneous Information *(hydrocephalus treatment, current shunt setting, etc.)*

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Hydrocephalus Association

| | Medications | Reason (headaches, seizures, asthma, etc.) | Form (pill, injections, liquid, patch, etc.) | Dosage | Amount | When (as needed, morning, bedtime, etc.) | Prescribed By (doctor) |
|---|---|---|---|---|---|---|---|
| Be sure to include ALL prescription drugs over-the-counter drugs, vitamins, and herbal supplements. | | | | | | | |
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