MEDICAL HISTORY

INSTRUCTIONS

Fill out this form to keep track of your medical history and other vital information regarding your health. Keep a printed copy always with you.

YOU SHOULD REVIEW THIS RECORD WHEN

Starting or stopping a new medicine, changing a dose and/or visiting your doctor.

Last Updated:

PERSONAL INFORMATION

Patient Name: Date of Birth:

Email: Phone Number:

EMERGENCY CONTACT INFORMATION

Name: Relationship to Patient:

Phone Number: Email:

Pharmacist: Phone Number:

Neurosurgeon Name: Phone Number:

Hospital:

OTHER PHYSICIANS

Primary Care Physician: Hospital:

Phone Number:

Neurologist: Hospital:

Phone Number:

Other Physician Specialty: Phone Number:

ALLERGIES AND REACTIONS

MEDICAL CONDITIONS

HYDROCEPHALUS RELATED SURGERIES

NON-HYDROCEPHALUS RELATED SURGERIES

MISCELLANEOUS INFORMATION *(hydrocephalus treatment, current shunt setting, etc.)*

MEDICATIONS

Be sure to include ALL prescription drugs over-the-counter drugs, vitamins, and herbal supplements.

MEDICATION NAME	REASON (headaches, seizures, asthma, etc.)	DOSAGE (1mg, 2.5ml, etc)	WHEN (as needed, morning, bedtime, etc.)	PRESCRIBED BY (doctor)