**EDS Medical History**

For: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Index:

* Doctor briefing pages (Not included in this draft)
* Insurance
* Doctor contact information
  + Primary care
  + Specialists
* Medications
  + Pharmacy
  + Prescription medications
  + Other meds/supplements
* Medical history
  + Allergies
  + Surgeries
  + Hospitalizations
  + Historical diagnosis list
  + Current issues list

**Health Insurance**

|  |
| --- |
| Provider:  Plan:  Group:  ID:  Address:  Phone:  Web site: |

**Primary care provider**

|  |
| --- |
| Doctor name:  Specialty:  First visit date:  Hospital affiliation:  Office address:  Phone:  Fax:  Email:  Web site: |

|  |
| --- |
| Doctor name:  Specialty:  From/to:  Hospital affiliation:  Office address:  Phone:  Fax:  Email:  Web site: |

|  |
| --- |
| Doctor name:  Specialty:  From/to:  Hospital affiliation:  Office address:  Phone:  Fax:  Email:  Web site: |

**Specialists**

|  |
| --- |
| Doctor name:  Specialty:  First visit date:  Hospital affiliation:  Office address:  Phone:  Fax:  Email:  Web site: |

|  |
| --- |
| Doctor name:  Specialty:  First visit date:  Hospital affiliation:  Office address:  Phone:  Fax:  Email:  Web site: |

|  |
| --- |
| Doctor name:  Specialty:  First visit date:  Hospital affiliation:  Office address:  Phone:  Fax:  Email:  Web site: |

**Specialists**

|  |
| --- |
| Doctor name:  Specialty:  First visit date:  Hospital affiliation:  Office address:  Phone:  Fax:  Email:  Web site: |

|  |
| --- |
| Doctor name:  Specialty:  First visit date:  Hospital affiliation:  Office address:  Phone:  Fax:  Email:  Web site: |

|  |
| --- |
| Doctor name:  Specialty:  First visit date:  Hospital affiliation:  Office address:  Phone:  Fax:  Email:  Web site: |

**Pharmacy**

|  |
| --- |
| Name:  Phone:  Address:  Hours open: |

|  |
| --- |
| Name:  Phone:  Address:  Hours open: |

|  |
| --- |
| Name:  Phone:  Address:  Hours open: |

**Prescription Medications**

|  |
| --- |
| Med name:  Amount in each pill:  How often do you take it:  Dates of medication:  Who prescribed it:  What was it prescribed for:  How much does it help:  What are the side effects: |

|  |
| --- |
| Med name:  Amount in each pill:  How often do you take it:  Dates of medication:  Who prescribed it:  What was it prescribed for:  How much does it help:  What are the side effects: |

|  |
| --- |
| Med name:  Amount in each pill:  How often do you take it:  Dates of medication:  Who prescribed it:  What was it prescribed for:  How much does it help:  What are the side effects: |

**Supplements and other medications**

|  |
| --- |
| Med /supplement name:  Amount in each pill:  How often do you take it:  Dates of medication:  Why do you take it:  How much does it help:  What are the side effects: |

|  |
| --- |
| Med /supplement name:  Amount in each pill:  How often do you take it:  Dates of medication:  Why do you take it:  How much does it help:  What are the side effects: |

|  |
| --- |
| Med /supplement name:  Amount in each pill:  How often do you take it:  Dates of medication:  Why do you take it:  How much does it help:  What are the side effects: |

**Allergies**

|  |
| --- |
| What are you allergic to:  What happens:  When did this first happen:  What helps: |

|  |
| --- |
| What are you allergic to:  What happens:  When did this first happen:  What helps: |

|  |
| --- |
| What are you allergic to:  What happens:  When did this first happen:  What helps: |

|  |
| --- |
| What are you allergic to:  What happens:  When did this first happen:  What helps: |

|  |
| --- |
| What are you allergic to:  What happens:  When did this first happen:  What helps: |

|  |
| --- |
| What are you allergic to:  What happens:  When did this first happen:  What helps: |

**Surgeries**

|  |
| --- |
| Surgery:  On what body part:  Why was this performed:  Who performed:  Where:  When  Complications:  How was the recovery:  Did it help: |

|  |
| --- |
| Surgery:  On what body part:  Why was this performed:  Who performed:  Where:  When  Complications:  How was the recovery:  Did it help: |

|  |
| --- |
| Surgery:  On what body part:  Why was this performed:  Who performed:  Where:  When  Complications:  How was the recovery:  Did it help: |

**Hospitalizations**

|  |
| --- |
| Why did you go in:  What tests did they do:  What happened while there:  Hospital name:  Hospital address:  When: |

|  |
| --- |
| Why did you go in:  What tests did they do:  What happened while there:  Hospital name:  Hospital address:  When: |

|  |
| --- |
| Why did you go in:  What tests did they do:  What happened while there:  Hospital name:  Hospital address:  When: |

|  |
| --- |
| Why did you go in:  What tests did they do:  What happened while there:  Hospital name:  Hospital address:  When: |

**Historical Diagnosis list**

|  |
| --- |
| Diagnosis:  Who made it:  When:  What was the basis for the diagnosis: |

|  |
| --- |
| Diagnosis:  Who made it:  When:  What was the basis for the diagnosis: |

|  |
| --- |
| Diagnosis:  Who made it:  When:  What was the basis for the diagnosis: |

**Current issues list**

|  |
| --- |
| Primary concern:  Have you been seen for this before:  What are you doing for it:  What have you tried:  What works:  What does not work |

|  |
| --- |
| Secondary concern:  Have you been seen for this before:  What are you doing for it:  What have you tried:  What works:  What does not work |