MEDICAL SUMMARY

Name **Date**
Address
Telephone Number

In Case Of Emergency:
Primary Contact – Name & Relationship - Address - Telephone Numbers
Secondary Contact - Name & Relationship - Address - Telephone Numbers
Third Contact – Name & Relationship - Address - Telephone Numbers

Medical Power of Attorney = Yes = Name & Relationship

Living Will & Advanced Directives = Yes **Organ Donor** = Yes

Primary Care Physician = Doctor's Name – Name of Practice – Address – Phone Numbers

Blood Type: xx

Conditions:

1. **Parkinson's Disease (PD)** – diagnosed in year
2. **"Major" Surgeries or Conditions** – type & date
3. **Choking and difficulty swallowing liquids because of PD**
4. **Many non-motor system conditions due to PD (**list them here**)**

DBS MEDCAL IMPLANTS: Two Deep Brain Stimulators (DBS) (Where surgery) (Doctor's names) for left & right side of brain with two controllers under the skin of upper chest. I usually carry a palm-sized external controller for emergencies that can be used to check the status of internal controllers and turn them ON/OFF. Other devices such as theft detectors or EKG can cause interference to or malfunction of the DBS devices. Both neuro-stimulatos & batteries replaced date and place – Left Serial #xxxxx Right Serial #xxxxx

WARNING! --- Contact Medtronics [www.medtronic.com] before using any external electronic medical device! MRI or exposure to any strong electrical or magnetic field – they may cause serious, permanent brain damage or death! Call Medtronic 1-800-510-6735 for MRI exam/tests and other device questions **Neuro Clinic Doctor Telephone:** Number **Surgeon is Dr. Name MD - Telephone:** Number

Flu Vaccines: date & type **Pneumonia Vaccines:** date & type **Tetanus Vaccines:** date & type **Other Vaccines:** date & type

Drug Allergies: List them here and what the reaction is

Drug Side Effects/Reactions: List them here and what the reaction is

Environmental Allergies: List them here and what the reaction is

Pharmacy/Drug Store: Name - Phone number --- Voice Mail Phone Number --- Address of

Insurance: Company Name Prescription Plan: Name and Type

PRESCRIPTION MEDICATIONS			
DRUG	**STRENGTH**	**DOSE & SCHEDULE**	**NAME OF DOCTOR AND CONDITION PRECRIBED FOR + ANY NOTES**

OVER THE COUNTER MEDICATIONS (INCLUDING HERBS & VITAMENS)			
DRUG / TYPE	**STRENGTH**	**DOSE & SCHEDULE (type)**	**CONDITION PRECRIBED FOR + NOTES**

MEDICAL HISTORY INFORMATION & PROCEDURES			
DATE	**ILLNESS/INJURY**	**DOCTOR'S NAME**	**COMMENTS**

PHYSICIANS & MEDICAL PROVIDERS			
DOCTOR'S NAME	**ADDRESS & WEBSITE URL**	**PHONE #'S**	**SPECIALITY**