Akron Children's Hospital

MEDICAL SUMMARY

Clear Form | Print Form

PATIENT INFORMATION

Patient Name: Last | First | Middle | Date of Birth: mm/dd/yyyy

Emergency Contact: Name | Relationship | Phone

Insurance Provider: Insurance Provider | Identification Number | Group Number

PHARMACY INFORMATION

Retail Pharmacy: | Phone:

Specialty Pharmacy: | Phone:

Primary Care Physician: | Phone:

ALLERGIES/CONTRAINDICATED MEDICATIONS

☐ *If Box is Checked, see Additional Information on separate sheet*

Medication Name	Reaction

MEDICAL DIAGNOSIS

☐ *If Box is Checked, see Additional Information on separate sheet*

Diagnosis	Specialist Name	Phone

MEDICATIONS

☐ *If Box is Checked, see Additional Information on separate sheet*

Medication Name	Dose	Frequency

SURGERIES/PROCEDURES

☐ *If Box is Checked, see Additional Information on separate sheet*

Date	Procedure	Facility

HOSPITALIZATIONS

☐ *If Box is Checked, see Additional Information on separate sheet*

Date	Duration	Reason	Facility

BLEEDING DISORDER INFORMATION

INHIBITOR:	☐ YES	☐ NO	☐ N/A	If Yes, when? _____
TARGET JOINT:	☐ YES	☐ NO		If Yes, location? _____
HEPATITIS C STATUS:	☐ POSITIVE	☐ NEGATIVE	☐ UNKNOWN	
HIV STATUS:	☐ POSITIVE	☐ NEGATIVE	☐ UNKNOWN	

Hemostasis & Thrombosis Center
Medical Summary Form
Rev. 6/20

Akron Children's Hospital

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(Additional)

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