MEDICAL HISTORY

This document outlines important recent medical history.

IMPORTANT: I have a rare, potentially life-threatening disease called familial chylomicronemia syndrome (FCS).

Patient Information

First Name: Middle Name: Last Name:

Nickname:

Address: City: State: Zip:

Primary phone: Work phone: Other phone:

Insurance provider: Policy number:

Blood type: Ethnicity:

Factors that may affect treatment:

Emergency Contact Information

Emergency contact name: Relation:

Primary phone: Work phone: Other phone:

☐ Has signed power of attorney for care

Healthcare provider emergency contact

Name: Provider type:

Work phone: Cell phone:

Other Medical Needs

Medical diagnoses/conditions:

Allergies:

Special technology needs (tubes, catheters, ports, etc.):

Precautions to take while dealing with technology:

Healthcare Providers

NAME	SPECIALTY	PHONE NUMBER	ADDRESS

CONTINUED ON BACK

Pharmacy Information

Pharmacy: Address:

Phone Number: Fax Number:

Medications

MEDICATION (including over-the-counter and supplements)	DATE STARTED	DATE ENDED	DOSAGE	SPECIAL INSTRUCTIONS

Recent ER Visits/Hospitalizations

DATE	SYMPTOMS	DIAGNOSIS	ADMITTED? (YES OR NO)

Recent Scans/Imaging

DATE	TYPE	REASON	DIAGNOSIS

Other Important Information

NOTE TO PATIENT: Be sure to keep detailed lab reports and other health documents in the FCS CareBook.