Name:_____ Date:_____
Address:_____ Social Security#:_____
City, State, Zip:_____ Do you smoke? Yes○No○
Phone:_____ Do you drink alcohol Yes○No○
Cell:_____ Do you use drugs? Yes○No○

Prescription Medications

Medication	Dosage	Prescribed For

OTC Medications

Medication	Dosage	Used For

Allergies and Intolerances to Medications

Medication	Symptoms of Reaction

Allergies and Intolerances to food

Hospitalizations, Surgeries, and Invasive Procedures

Date	Procedure

Significant Illnesses

Date	Illness

Significant Tests

Date	Test	Results

Current Health Issues

Family History

Relative	Health Problems
Father	
Mother	
∘Brother ∘Sister	
∘Brother ∘Sister	
∘Brother ∘Sister	
∘Brother ∘Sister	
∘Brother ∘Sister	
∘Brother ∘Sister	

Emergency Contact

Name	
Relationship	
Phone	
Cell	

Name	
Relationship	
Phone	
Cell	

Physicians

Physician Name	
Speciality	
Practice Name	
Street Address	
City, State, Zip	
Phone	
Facsimile	

Physician Name	
Speciality	
Practice Name	
Street Address	
City, State, Zip	
Phone	
Facsimile	

Physician Name	
Speciality	
Practice Name	
Street Address	
City, State, Zip	
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Phone	
Facsimile	

Physician Name	
Speciality	
Practice Name	
Street Address	
City, State, Zip	
Phone	
Facsimile	

Physician Name	
Speciality	
Practice Name	
Street Address	
City, State, Zip	
Phone	
Facsimile	

Pharmacies

Pharmacy 1	
Address	
City, State, Zip	
Phone	
Facsimile	

Pharmacy 2	
Address	
City, State, Zip	
Phone	
Facsimile	

Pharmacy 3	
Address	
City, State, Zip	
Phone	
Facsimile	

Pharmacy 4	
Address	
City, State, Zip	
Phone	
Facsimile	