

MEDICAL INFORMATION FORM

PERSONAL DETAILS

First Name: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Home Phone: _____ Mobile Phone: _____

E-Mail: _____

TREATING PHYSICIANS

Include primary care, specialists and any active treating physicians.

Physician Name	Specialty	Address	Phone

ALLERGIES

List your allergies and describe the reactions to your body.

Allergy	Reaction	Location	Medication, if any

DATE: _____

MEDICATIONS & SUPPLEMENTS

*List the medications you are currently taking including the dosage.
Use the second table for supplements, vitamins, and herbal remedies.*

Medication	Dosage	Prescribing Physician	Pharmacy
Supplement, Vitamins, Herbal Remedies	Dosage	Use	Pharmacy

VACCINE HISTORY

*List most recent vaccines for influenza, COVID, pneumonia, shingles
and other infectious diseases.*

Vaccine	Booster? (Y/N)	Location Received	Year

DATE: _____