Date Completed _____

Patient Medical Information Sheet

FIRST NAME	INITIAL	LAST NAME	SOCIAL SECURITY NUMBER

STREET	CITY	STATE	ZIP	TELEPHONE

DATE OF BIRTH	MALE/FEMALE	HEIGHT	WEIGHT	HAIR COLOR	EYE COLOR	BLOOD TYPE	RELIGION

List hearing difficulties	DENTURES UPPER LOWER	UNABLE TO SPEAK ☐
List vision difficulties	NATIVE LANGUAGE IF NOT ENGLISH	

Identifying Marks

Current Medical Conditions

Past Medical Conditions

Current Medications: Dosage and Frequency

Allergies to Medication

Doctors Name and Telephone Number

Last hospitalization

Special Instructions such as health directives, etc...

Health Insurance Policy

Emergency Contact Notifications – Name – Address – Phone – Relationship

PLEASE PRINT CLEARLY