

MEDICAL INFORMATION SHEET

NAME: _____

DATE OF BIRTH: _____

DOCTOR'S NAME _____ DOCTOR'S PHONE

HOSPITAL PREFERENCE: _____

EMERGENCY PHONE INFORMATION

MAIN CONTACT:

NAME: _____ PHONE: _____

SECONDARY CONTACT:

NAME _____ PHONE: _____

MEDICAL HISTORY: ___HEART ATTACK ___DIABETES ___STROKE ___ASTHMA
___HIGH BLOOD PRESSURE _____OTHER (PLEASE
SPECIFY)

BLOOD TYPE: _____

ALLERGIES TO MEDICINES:

OTHER ALLERGIES:

**PLEASE LIST OR ATTACHED ALL MEDICATIONS THAT YOU ARE
CURRENTLY TAKING AND ANY SPECIAL INSTRUCTIONS REGARDING
THESE MEDICATIONS:**
