

**FAMILY MEDICAL
INFORMATION SHEET**

Name:

Primary Doctor Name and Telephone Number:

Health Card Number:

Health Insurance Number:

Emergency Contact Name and Relationship:

Telephone Number:

Blood Type:

Allergies List any medications or foods that you are allergic to and your reaction.

Medications List all prescription and over-the-counter medications.

Medication	Dose	Purpose/Treatment

Vitamins List all vitamins and supplements.

Name	Quantity/ Purpose

Medical History List all past surgeries and medical issues.

Surgery	Date / Reason
Medical Issues	Date / Explanation
Family History	Illness / Paternal or Maternal Side

