FAMILY MEDICAL INFORMATION SHEET

Your Name:

Primary Doctor Name and Telephone Number:
Health Card Number:
Health Insurance Number:

Emergency Contact Name and Relationship:
Telephone Number:

Your 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

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

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