

# Medical Needs Form

## Personal Information

1. Full Name:

2. Date of Birth:

3. Gender:

4. Address:

5. Phone Number:

6. Emergency Contact:

Name:

Relationship:

Phone Number:

## Medical History

### General Health Information:

1. Primary Care Physician:

Name:

Phone Number:

2. Known Allergies:

Allergen:

Reaction:

### Current Medications:

1. Medication 1:

Name:

Dosage:

Frequency:

Prescribing Doctor:

2. Medication 2:

Name:

Dosage:

Frequency:

Prescribing Doctor:

**Chronic Conditions**

1. Condition 1:

Description:

Treatment Plan:

2. Condition 2:

Description:

Treatment Plan:

**Special Instructions or Considerations**

1. Dietary Restrictions:

Details:

2. Mobility Requirements:

Assistive Devices:

Special Accommodations Needed:

3. Communication Preferences:

Preferred Language:

Assistive Communication Devices:

**Insurance Information**

1. Insurance Provider:

2. Policy Number:

3. Emergency Contact for Insurance:

Name:

Phone Number:

**Additional Information**

Preferred Hospital or Medical Facility:

Additional Emergency Instructions: