My Medical Information Sheet

Personal Medical History

Illness or health concerns	Started from (date)	How is it treated (e.g., medication, diet)

Family Medical History

Family member	Illness or condition	Age currently or at death

Health Provider and Pharmacy Information

Health provider (e.g., primary care, women specialist)	Name & affiliated medical group	Telephone	Address	Last visit date

Pharmacy	Telephone	Address

Medication, Lifestyle, Other

Medication and Supplements	Purpose	Dosage	Started to take from (date)

Lifestyle (e.g., physical activity, smoking)	Frequency (e.g., # per week)