YOUR FULL NAME
Medical Records
as of: DATE, 2019

<table>
<tr><td>Patient Contact Info:

Your name
Your phone number
DOB: 1/23/1987
Your street address
City, state, ZIP</td><td>Primary Insurance: Company
Policy #123456789
Contact info

Secondary: Name of secondary
Policy #456789
Contact info</td></tr>
<tr><td>Primary Care Physician:
Doctor's name
Doctor's Phone</td><td>Pharmacy Name
Pharmacy address
Pharmacy phone</td></tr>
<tr><td>Specialists (Add others):

Cardiologist:
Name
Phone
Orthopedist:
Name
Phone</td><td>Miscellaneous (Add others):

Chiropractor:
Name
Phone
Physical Therapist:
Name
Phone</td></tr>
<tr><td colspan="2">Contacts: Primary contact/Relationship: Cell (555) 123-4567; Home: (555) 678-9123
Secondary Emergency Contact/Relationship: Name, Cell: (555) 876-5432</td></tr>
</table>

Current Medications
as of: DATE, 2019

Medication	Dosage	Reason
Name of med, 10 mg.	1 pill daily	Blood pressure
Name of med, 800 mg.	1 tablet twice a day as needed	Migraine
Name of med, .5 mg	1 tablet as needed	Toothache
Name of med, .25 mg.	1 tablet at bedtime as needed	Restless legs
Name of med, Topical Gel 1%	Topical gel; use as needed	Muscle pain
Name of over-the-counter med	2 drops in each eye as needed	Itchy eyes

Other: I do not drink coffee or caffeinated beverages or alcohol. I am lactose intolerant.
Allergies or reactions: List them and reactions.
Add anything else that might be relevant.