# HILL PARK MEDICAL CENTER
## PATIENT MEDICAL DATA

Name: ______________________________ Date: ____________

Please list all allergies and sensitivities. (drugs, foods, chemicals, environmental): ____________

Please list all current medications (include over-the-counter and prescription medications):

| *name* | *dose* | *how often* |
|---|---|---|
| | | |
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| | | |
| | | |
| | | |

Supplement list (Please list all herbs, vitamins, nutritional supplements, with dosage if possible): ____________

Please list all medical diagnoses: ____________

Please list all surgeries (with year): ____________

Please list all hospitalizations (with year): ____________

Please list all therapies you use (acupuncture, massage, physical therapy etc.): ____________