

# Medical Information Sheet

**Prepared for:**

**MacDonald Law Office, LLC**  
4650 W. Spencer Street  
Appleton, WI 54914

**Phone: 920-560-4646**  
**Fax: 920-968-4650**



**Please bring this form with you to your initial meeting. All information provided herein is considered CONFIDENTIAL INFORMATION by MACDONALD LAW OFFICE, LLC and will not be shared with anyone outside of our office. Please call us if you have any questions.**

**Date Completed:** \_\_\_\_\_

**Please Print**

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Birth date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_

Health Insurance information: \_\_\_\_\_

Primary care physician: \_\_\_\_\_

Phone number of physician: \_\_\_\_\_

Address of physician: \_\_\_\_\_

\_\_\_\_\_

Current Medications and dosages \_\_\_\_\_

\_\_\_\_\_

Allergies: \_\_\_\_\_

Medical History: KNOWN MEDICAL PROBLEMS

- Seizures?
- Heart?
- Diabetes?
- Lung?
- Cancer?
- Stroke?
- Blood Pressure?
- Hepatitis?
- HIV/AIDS?

Other?

Other?

Other?

Explain \_\_\_\_\_

Marital Status:  Single  Married, Date: \_\_\_\_\_

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Birth date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_

Health Insurance information: \_\_\_\_\_

Primary care physician: \_\_\_\_\_

Phone number of physician: \_\_\_\_\_

Address of physician: \_\_\_\_\_

\_\_\_\_\_

Current Medications and dosages \_\_\_\_\_

\_\_\_\_\_

Allergies: \_\_\_\_\_

Medical History: KNOWN MEDICAL PROBLEMS

- Seizures?
- Heart?
- Diabetes?
- Lung?
- Cancer?
- Stroke?
- Blood Pressure?
- Hepatitis?
- HIV/AIDS?
- Other?
- Other?
- Other?

Explain \_\_\_\_\_

\_\_\_\_\_

# CONTACT INFORMATION

## Please contact the following in case of emergency:

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Male  Female Relationship: \_\_\_\_\_

Home address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home telephone \_\_\_\_\_

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Male  Female Relationship: \_\_\_\_\_

Home address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home telephone \_\_\_\_\_

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Male  Female Relationship: \_\_\_\_\_

Home address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home telephone \_\_\_\_\_

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Male  Female Relationship: \_\_\_\_\_

Home address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home telephone \_\_\_\_\_

PLEASE USE THIS SPACE TO WRITE IN HEALTH-RELATED INFORMATION: