Life Skills Recovery Ranch

MEDICAL RECORD

PATIENT INFORMATION			
Full Name:	**Date of Birth:**	**Social Security Number:**	
Home Address: (Street, City, State & Zip)		**Phone Number:**	
Physician:	**Physician's Phone Number:**	**Pharmacy:**	**Pharmacy's Phone Number:**

PAST MEDICAL HISTORY
1.
2.
3.
4.
Allergies to Medications:

CURRENT MEDICATION REGIMENT		
MEDICATION	**DOSAGE AND TIME TAKEN**	**PRESCRIPTION START AND END DATES, PRESCRIBING PHYSICIAN**