Medical Expenses Worksheet

Client:_____ **Tax Year:**_____

Medication and Drugs

Prescribed Controlled Substances:_____ Other:_____

Insulin:_____ Total Medication and Drugs:_____

Doctors, Dentists, Psychiatrists, Chiropractors, C/S Practitioners, Acupuncture, Others

Dr. _____ Dr. _____

Dr. _____ Dr. _____

Dr. _____ Dr. _____

Dr. _____ Dr. _____

Dr. _____ Dr. _____

Total Doctors & Dentists:_____

Hospitals

Name & Location:_____

Name & Location:_____

Name & Location:_____

Name & Location:_____

Total Hospital Expenses:_____

Other Medical & Dental Expenses

Anesthesia: _____ X-rays: _____

Oxygen: _____ Wheel Chair: _____

Laboratories: _____ Clinics: _____

Nurses: _____ Physical Therapy:_____

Ambulance: _____ Eyeglasses:_____

Psychiatric Care: _____ Contact Lenses: _____

Mental Therapy: _____ Canes:_____

Optometrists: _____ Braces: _____

Hearing Aids: _____ Travel & Transportation: _____

Hospital Equipment: _____

Orthopedic Shoes: _____ Total Other Medical & Dental Expenses:_____

Crutches: _____ _____

Humidifiers: _____