Client Name _____

2025 Itemized Deductions

Please fill in amounts where applicable.

Medical Expenses (do NOT include expenses paid through an HSA)

Doctor/dentist bills _____
Hospital bills _____
Medical lodging _____
Lab and x-ray _____
Glasses, hearing aids _____
Nursing home expenses _____
Insurance reimbursements _____
Medical supplies/equipment _____
Prescription drugs _____
Medical mileage _____

Insurance Premiums (do NOT include those withheld from SS or paid pretax on W-2)

Health ins. premiums _____
Dental & vision ins. premiums _____
Long-term care premiums taxpayer _____
spouse _____

Contributions

House of worship _____
Payroll deductions _____
Other cash _____
Charity mileage _____
*Non-cash items _____

*Please itemize if greater than $500. Provide charity name, date and what was contributed.