Medical History Form

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Patient Information

Full Name ______________________

Date of Birth ______________________

Gender ______________________

Address ______________________

Phone Number / Email ______________________

Past Medical History

Chronic Illnesses ______________________

Past Surgeries ______________________

Hospitalizations ______________________

Family Health History

Diabetes ______________________

Hypertension ______________________

Heart Disease ______________________

Cancer ______________________

Other ______________________

Allergies

Drug Allergies ______________________

Food Allergies ______________________

Environmental Allergies ______________________

Current Medications

Prescription Drugs ______________________

Over-the-Counter Medications ______________________

Supplements ______________________

Lifestyle & Social History

Smoking ______________________________

Alcohol Use ______________________________

Physical Activity ______________________________

Other Relevant Factors ______________________________

Consent & Authorization

HIPAA Acknowledgment ______________________________

Consent for Treatment ______________________________

Signature & Date ______________________________

Practitioner Name: ____________________

Clinic Address: ____________________

Contact Number / Fax / Email: ____________________

Signature: ____________________

Date: ____________________

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