Chronic Condition Medical History Record

Patient Information

Full Name

Date of Birth

Gender

Phone

Email

Address

Chronic Condition Information

Primary Diagnosis

Date Diagnosed

Current Status

Symptoms / Notes

Medication History

Medication Name	Dosage	Frequency	Start Date	End Date

Previous Treatments / Surgeries

Treatment / Surgery	Date	Outcome / Notes

Family Medical History

Please describe any relevant family history of chronic conditions:

Allergies

List any known allergies (medications, foods, etc.):

Healthcare Provider

Physician/Provider Name

Contact Information

Facility/Clinic