Comprehensive Adult Medical History Form

Personal Information

Full Name

Date of Birth

Gender

Select...

Email

Phone

Address

Emergency Contact

Contact Name

Relationship

Phone

Insurance Information

Insurance Provider

Policy Number

Medical History

Have you ever had or do you currently have any of the following? (Check all that apply)

- [ ] Diabetes
- [ ] Hypertension
- [ ] Heart Disease

- [ ] Asthma
- [ ] Stroke
- [ ] Cancer
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Arthritis
- [ ] Other

If other, please specify:

Current Medications

Please list current medications (include dosages & frequency)

Allergies

Medication/Food/Other Allergies (please specify reaction):

Surgeries & Hospitalizations

List all major surgeries/hospitalizations and years:

Family History

Indicate if any immediate family members have had the following (write relation):

Diabetes

Heart Disease

Cancer

Stroke

Other

Social History

Do you smoke?

Select...

Do you drink alcohol?

Select...

Do you exercise regularly?

Select...

Occupation

Review of Systems

Check any current symptoms:

- [ ] Fever
- [ ] Weight Loss
- [ ] Fatigue
- [ ] Cough
- [ ] Chest Pain
- [ ] Palpitations
- [ ] Shortness of Breath
- [ ] Nausea/Vomiting
- [ ] Abdominal Pain
- [ ] Joint Pain
- [ ] Headache
- [ ] Other

If other, please specify:

Additional Notes