Adult Patient Medical History Questionnaire

Personal Information

Full Name

Date of Birth

Gender

Address

Phone Number

Email

Emergency Contact

Name

Phone Number

Relationship

Medical History

Do you have or have you had any of the following? (Check all that apply)

- [ ] Diabetes
- [ ] Hypertension
- [ ] Heart Disease
- [ ] Stroke
- [ ] Asthma
- [ ] Cancer
- [ ] Other

If "Other", please specify

Allergies (medications, foods, etc.)

Current Medications (include dosage & frequency)

Past Surgeries or Hospitalizations (with year)

Lifestyle

Do you smoke?

- ○ No
- ○ Yes
- ○ Former

Do you drink alcohol?

- ○ No
- ○ Yes
- ○ Occasionally

Physical Activity (Type & Frequency)

Family Medical History

Has any blood relative had any of the following? (Check all that apply)

- ☐ Diabetes
- ☐ Hypertension
- ☐ Heart Disease
- ☐ Cancer
- ☐ Stroke
- ☐ Other

If "Other", please specify

Additional Information

Please include any other information about your health you feel is important