Adult Health History Intake Sheet

Personal Information

Full Name

Date of Birth

Sex

Select

Phone Number

Email Address

Address

Emergency Contact

Name

Phone

Relationship

Primary Care Provider

Provider Name

Phone Number

Medical History

Have you ever been diagnosed with any of the following? (Check all that apply)

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

If other, please specify

Allergies

List any allergies (medications, foods, environmental):

Medications

List all current medications (including vitamins/supplements):

Surgical History

List all major surgeries and dates:

Family History

List any significant family medical history (e.g. diabetes, cancer, heart disease):

Social History

Do you smoke?

Select

Do you drink alcohol?

Select

Do you exercise regularly?

Select

Occupation

Other Concerns/Symptoms

Please describe any health concerns or symptoms you would like to discuss: