Comprehensive Patient Medical History Form

Personal Information

First Name

Date of Birth

Gender

Select

Last Name

Contact Number

Email Address

Address

Emergency Contact

Name

Relationship

Phone Number

Insurance Information

Provider

Policy Number

Medical History

Known Allergies

Current Medications

Past & Present Medical Conditions (e.g. Hypertension, Asthma)

Surgeries / Hospitalizations (with dates)

Family Medical History

List any significant family medical history

Lifestyle

Do you smoke?

Select

Do you consume alcohol?

Select

Physical Activity / Exercise

Other Information

Describe any current symptoms, concerns, or reasons for visit