

# Chronic Illness and Medication Questionnaire

Please fill out this questionnaire. This document is designed to be printed and kept with your medical records or shared with your healthcare providers.

## 1. Personal Information

Full Name:

Date of Birth (MM/DD/YYYY):

Phone Number:

Emergency Contact Name & Phone:

Today's Date:

## 2. Chronic Illnesses & Diagnosed Conditions

Please list any chronic illnesses or long-term medical conditions you have been diagnosed with (e.g., Hypertension, Diabetes, Asthma, Depression).

Medical Condition / Diagnosis	Year of Diagnosis	Current Status / Notes
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

## 3. Current Medications & Supplements

Please list all prescription medications, over-the-counter drugs, vitamins, and herbal supplements you currently take.

Medication Name	Dosage (e.g., 50mg)	Frequency (e.g., Once daily)	Reason for Taking
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

## 4. Medication Allergies & Adverse Reactions

Please list any medications you cannot take due to allergies or severe side effects.

Medication Name	Reaction Experienced (e.g., Rash, Swelling, Nausea)
<input type="text"/>	<input type="text"/>

Medication Name	Reaction Experienced (e.g., Rash, Swelling, Nausea)

## 5. Healthcare Providers & Pharmacy Information

Primary Care Physician Name:

Primary Care Clinic Phone Number:

Preferred Pharmacy Name:

Pharmacy Phone Number & Location: