

General Patient Medical History Form

Please complete all sections of this medical history form. This information is confidential and will become part of your medical record.

1. Patient Demographics

Full Name:

Date of Birth (MM/DD/YYYY): Gender:

Phone Number: Email Address:

Street Address:

Emergency Contact Name: Relationship: Phone:

2. Personal Medical History

Please indicate if you have ever been diagnosed with or treated for any of the following conditions (Write "Yes" or "No"):

High Blood Pressure: Heart Disease / Heart Attack:

Asthma / COPD / Lung Disease: Diabetes:

Kidney Disease: Liver Disease (e.g., Hepatitis):

Stroke: Cancer (Specify type below):

Depression / Anxiety: Thyroid Disorder:

Other diagnosed medical conditions:

3. Surgical History & Hospitalizations

Please list any past surgeries, major injuries, or hospitalizations, along with the approximate year:

1. Operation/Reason: Year:

2. Operation/Reason: Year:

3. Operation/Reason: Year:

4. Current Medications & Allergies

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

Please list any known drug, food, or environmental allergies (e.g., Penicillin, Latex):

5. Family Medical History

Have any of your immediate family members (parents, siblings, grandparents) had any of the following? (Write relationship, e.g., "Father", "Mother"):

Heart Disease: Stroke:

Diabetes: Cancer (Specify type):

High Blood Pressure: Mental Illness:

6. Social History

Do you use tobacco products? (Yes/No/Former): If yes/former, frequency/amount:

Do you drink alcohol? (Yes/No): If yes, drinks per week:

Do you use any recreational substances? (Yes/No): Occupation:

7. Acknowledgement & Signature

To the best of my knowledge, the questions on this form have been accurately answered.

Patient/Guardian Signature: Date: