

Patient Medical History and Questionnaire

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

1. Patient Information

Full Name:	<input type="text"/>	Date of Birth:	<input type="text"/>
Gender/Pronouns:	<input type="text"/>	Phone Number:	<input type="text"/>
Email Address:	<input type="text"/>	Occupation:	<input type="text"/>
Emergency Contact Name:	<input type="text"/>	Emergency Contact Relationship:	<input type="text"/>
Emergency Contact Phone:	<input type="text"/>		

2. Current Medical Conditions

Please list any current medical conditions you are actively treating (e.g., High Blood Pressure, Diabetes, Asthma):

Condition 1:	<input type="text"/>	Date of Diagnosis:	<input type="text"/>
Condition 2:	<input type="text"/>	Date of Diagnosis:	<input type="text"/>
Condition 3:	<input type="text"/>	Date of Diagnosis:	<input type="text"/>
Other Conditions:	<input type="text"/>		

3. Allergies & Medications

Drug/Food/Environmental Allergies:	<input type="text"/>
Reaction Experienced:	<input type="text"/>

Please list all current prescription medications, over-the-counter medications, vitamins, and supplements:

Medication Name & Dosage:	<input type="text"/>	Frequency (Times per day/week):	<input type="text"/>
Medication Name & Dosage:	<input type="text"/>	Frequency (Times per day/week):	<input type="text"/>
Medication Name & Dosage:	<input type="text"/>	Frequency (Times per day/week):	<input type="text"/>

4. Surgical History & Hospitalizations

Surgery/Reason for Hospitalization:	<input type="text"/>	Approximate Date/Year:	<input type="text"/>
Surgery/Reason for Hospitalization:	<input type="text"/>	Approximate Date/Year:	<input type="text"/>

5. Family Health History

Please state if any immediate family members (parents, siblings, grandparents) have a history of the following:

Heart Disease (Relationship):	<input type="text"/>
High Blood Pressure (Relationship):	<input type="text"/>
Diabetes (Relationship):	<input type="text"/>
Cancer (Type and Relationship):	<input type="text"/>
Stroke (Relationship):	<input type="text"/>
Other Hereditary Conditions:	<input type="text"/>

6. Lifestyle & Social History

Tobacco Use (Yes/No, Type, Quantity per day):

Alcohol Use (Yes/No, Number of drinks per week):

Recreational Drug Use (Yes/No, Frequency):

Caffeine Intake (Daily amount):

Exercise Routine (Type and times per week):

7. Questionnaire / Reason for Visit

What is the primary reason for your visit today?

When did your symptoms first begin?

Rate your pain scale (from 1 to 10, with 10 being the worst):

Are symptoms constant, or do they come and go?

What makes the symptoms better or worse?

8. Signatures

I certify that the above information is correct to the best of my knowledge.

Patient/Guardian Signature: Date Signed: