Adult Medical History Questionnaire

Please complete this comprehensive form to help your healthcare provider understand your health history and current concerns.

Patient Information

Please provide your personal and emergency contact details.

Full Name *

First Name Last Name

Date of Birth (MM/DD/YYYY) *

Phone Number *

Please enter a valid phone number.

Email Address *

example@example.com

Today's Date (MM/DD/YYYY) *

Address (please include street, city, state, and zip code) *

Emergency Contact Name (if applicable)

Emergency Contact Phone

Please enter a valid phone number.

Relationship to Emergency Contact

Primary Care Provider

Information about your primary care physician.

Primary Care Physician Name

Physician Phone Number

Please enter a valid phone number.

Last medical visit date (MM/DD/YYYY)

Current Health Concerns

Tell us about your current health concerns or symptoms.

What health concerns or symptoms bring you in today? *

When did these symptoms begin?

Have you been treated for this problem before? *

- Yes

◯ No

If yes, describe previous treatment:

Past Medical History

Please check any conditions you have now or have had in the past.

Please check any medical conditions you have now or have had in the past:

- ☐ High blood pressure
- ☐ Heart disease
- ☐ Heart attack
- ☐ Stroke or TIA
- ☐ High cholesterol
- ☐ Diabetes (Type 1 or Type 2)
- ☐ Thyroid disease
- ☐ Asthma
- ☐ COPD or lung disease
- ☐ Sleep apnea
- ☐ Kidney disease
- ☐ Liver disease / hepatitis
- ☐ Cancer (any type)
- ☐ Autoimmune disease
- ☐ Seizure disorder
- ☐ Neurological conditions
- ☐ Migraines
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Chronic pain
- ☐ Mental health conditions (anxiety, depression, bipolar, PTSD)
- ☐ Substance use disorder
- ☐ Eating disorder
- ☐ HIV/AIDS
- ☐ Blood clotting disorder
- ☐ Anemia
- ☐ GERD / acid reflux
- ☐ IBS or bowel disorders
- ☐ Reproductive health conditions

☐ Other

If any checked, please describe:

Surgical & Hospitalization History

Tell us about any previous surgeries, hospitalizations, or major illnesses.

List previous surgeries (name of procedure & approximate date):

List hospitalizations or major illnesses:

Medications

Please list all prescription and non-prescription medications you are taking.

Are you currently taking prescription medications?

◯ Yes
◯ No

If yes, list all medications (name, dose, frequency):

Do you take over-the-counter medications, vitamins, or supplements?

- ◯ Yes
- ◯ No

If yes, list them:

Allergies

Please list any allergies and the reactions you experience.

Do you have allergies to medications, foods, latex, adhesives, or environmental triggers?

- ◯ Yes
- ◯ No

If yes, list allergies and reactions:

Family Medical History

Check any conditions that run in your immediate family (parents, siblings, grandparents).

Check any conditions that run in your immediate family:

- ☐ Heart disease
- ☐ High blood pressure

- ☐ Stroke
- ☐ Diabetes
- ☐ Cancer
- ☐ Thyroid disease
- ☐ Mental health disorders
- ☐ Autoimmune diseases
- ☐ Seizures
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Blood clotting disorders
- ☐ Other

If any selected, provide details:

Social & Lifestyle History

Tell us about your lifestyle habits and living situation.

Tobacco use

- ◯ Yes
- ◯ No
- ◯ Former

If yes, type and amount:

Alcohol use

- ◯ Yes
- ◯ No
- ◯ Occasionally

Recreational drug use

- ◯ Yes
- ◯ No

If yes, describe:

Exercise habits

Occupation

Living situation

- ◯ Alone
- ◯ With family
- ◯ With partner
- ◯ With roommates
- ◯ Other

Women's Health (Optional Section)

Please complete this section if applicable.

Are you pregnant or possibly pregnant?

- ◯ Yes
- ◯ No
- ◯ Unsure

Are you currently breastfeeding?

- ◯ Yes
- ◯ No

Last menstrual period

Any reproductive health conditions

Review of Systems

Check any symptoms you are currently experiencing.

Check any symptoms you are currently experiencing:

- ☐ Fever or chills
- ☐ Fatigue
- ☐ Weight loss or gain
- ☐ Headache
- ☐ Vision changes
- ☐ Hearing changes
- ☐ Congestion or sinus issues
- ☐ Sore throat
- ☐ Cough
- ☐ Shortness of breath
- ☐ Chest pain
- ☐ Palpitations
- ☐ Abdominal pain
- ☐ Nausea / vomiting
- ☐ Diarrhea / constipation
- ☐ Blood in stool
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Numbness or tingling
- ☐ Dizziness
- ☐ Trouble sleeping

- ☐ Anxiety or depression
- ☐ Rash or itching
- ☐ Bruising or bleeding
- ☐ Other

If any checked, please describe:

Immunization History

Please check any immunizations you have received.

Please check any immunizations you have received:

- ☐ Influenza
- ☐ COVID-19
- ☐ Tetanus / Tdap
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Pneumococcal
- ☐ Shingles
- ☐ Childhood vaccines
- ☐ Unsure

Additional Notes for Provider

Use this space for anything else you'd like your provider to know.

Anything else you'd like your provider to know:

Consent & Acknowledgment

Please confirm your agreement below.

I confirm the information provided in this Medical History Form is accurate to the best of my knowledge. *

- ☐ I confirm the information provided in this Medical History Form is accurate to the best of my knowledge.
- ☐ I agree to inform my provider of any changes in my health status.

Signature Section

Please provide your name, signature, and date.

Printed Name *

Signature (typed or digital) *

Date (MM/DD/YYYY) *