Health History Intake Form

Personal Information

Full Name

Date of Birth

Gender

Phone Number

Email Address

Address

Emergency Contact

Name

Relationship

Phone Number

Medical History

Primary Physician

Current medical conditions / diagnoses

Previous surgeries / hospitalizations

Current medications (include dosage)

Allergies (medications, food, etc.)

Family Medical History

Significant family illnesses (e.g., diabetes, cancer, heart disease, etc.)

Lifestyle

Do you smoke?

Alcohol use?

Exercise frequency

Describe your typical diet

Other relevant lifestyle factors

Other Information

Primary concerns/reason for today's visit

Additional notes