

# Adult Medical History Form

This detailed **medical history form** sample for adults is designed to collect comprehensive health information, ensuring accurate diagnosis and personalized care. It includes sections on past illnesses, surgeries, medications, allergies, and family medical history. Using this form helps healthcare providers track patient health and make informed medical decisions.

## Personal Information

**Full Name:**

**Date of Birth:**

**Gender:**

 --Select-- ▾

**Phone:**

**Email:**

## Past Medical History

Condition	Yes/No	Details
Diabetes	<input type="checkbox"/>	<input type="text"/>
Hypertension	<input type="checkbox"/>	<input type="text"/>
Heart Disease	<input type="checkbox"/>	<input type="text"/>
Asthma	<input type="checkbox"/>	<input type="text"/>
Other (Specify)	<input type="checkbox"/>	<input type="text"/>

## Surgeries and Hospitalizations

Procedure/Hospitalization	Date	Reason/Outcome
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

## Current Medications

Medication Name	Dosage	Frequency	Reason
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

## Allergies

**Drug Allergies:**

None

**Food Allergies:**

None

**Other Allergies:**

None

## Family Medical History

Family Member	Diabetes	Heart Disease	Cancer	Other (Specify)
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

## Social History

**Occupation:****Smoking:** **Alcohol Use:** **Exercise Frequency:**

e.g., 3 times per week

## Immunization History

**Are your immunizations up to date?** **Other Relevant Vaccines (specify):** 

## Additional Information

**Please provide any additional health information or concerns:**