Confidential Medical History Form

This **confidential medical history form** sample includes a detailed consent section to ensure patient privacy and compliance with legal standards. It allows healthcare providers to collect essential health information securely while obtaining explicit permission for data use. This form is designed to facilitate clear communication and protect sensitive medical details.

Patient Information

Full Name:

Date of Birth:

Address:

Phone Number:

Email:

Medical History

Known Allergies:

Past or Current Medical Conditions:

Current Medications:

Previous Surgeries/Hospitalizations:

Family Medical History:

Consent & Authorization

Confidentiality Assurance:
Your medical information will be kept strictly confidential and will only be disclosed to authorized healthcare professionals directly involved in your care, unless otherwise required by law.

☐ **I hereby consent** to the collection, use, and sharing of my medical information by the healthcare provider for the purposes of diagnosis, treatment, and administrative processes in accordance with applicable privacy laws. I have read and understand the confidentiality policy stated above.

Signature of Patient (or Parent/Guardian):

Date:

Submit