Medical History Form - New Patient

Download our **printable medical history form sample** designed specifically for new patients to ensure comprehensive and accurate health records. This easy-to-use form captures vital medical information, aiding healthcare providers in delivering personalized care. Streamline patient intake with a clear and organized document tailored to clinical needs.

Patient Information

Full Name:		Date of Birth:	
Address:			
Phone Number:		Email:	
Emergency Contact:		Contact Phone:	

Medical History

Condition	Yes	No	Details
Diabetes	☐	☐	
Hypertension	☐	☐	
Heart Disease	☐	☐	
Asthma	☐	☐	
Allergies	☐	☐	
Other (Specify)			

Current Medications

Medication Name	Dosage	Frequency

Surgical History

Type of Surgery	Date	Hospital/Doctor

Family Medical History

Condition	Family Member(s) Affected
Diabetes	
Heart Disease	
Cancer	

Other	_____

Lifestyle

Do you smoke?	☐ Yes ☐ No	If yes, how much?	_____
Do you drink alcohol?	☐ Yes ☐ No	If yes, how often?	_____
Recreational drug use?	☐ Yes ☐ No	If yes, please specify:	_____

Immunization Status

Tetanus	_____	Flu Shot	_____
Hepatitis B	_____	Other	_____

Allergies

Allergen	Reaction
_____	_____
_____	_____

Additional Information

Patient Signature:	_____	Date:	_____