Chronic Disease Management Medical History Form

Personal Information

Full Name

Date of Birth

Gender

Contact Number

Address

Chronic Disease Information

Chronic Diseases (e.g. diabetes, hypertension, asthma)

Date of First Diagnosis

Treating Physician

Current Medications

List all current medications

Allergies

Drug/Other Allergies

Relevant Medical History

Past Surgeries/Hospitalizations

Family History of Chronic Diseases

Lifestyle Information

Do you smoke?

Do you drink alcohol?

Physical Activity (frequency/type)

Dietary Habits

Other Notes / Concerns

Any Other Relevant Information