Medical Health Questionnaire

Patient Information
Full Name:
Date of Birth:
Age:
Address:
Phone Number:
Emergency Contact:
Relationship:
Emergency Contact Phone:

Medical History		
1. Current Medications		
Medication Name:	Dosage:	Frequency:
2. Allergies:		
Allergy:	Reaction:	
Allergy:	Reaction:	
Allergy:	Reaction:	
3. Chronic Conditions:		
4. Family Medical History		
Father:		
Mother:		
Sibling:		

Lifestyle Habits
1. Smoking
Current Smoker:
Pack Years (if applicable):
2. Alcohol Consumption
Average Drinks per Week:
Type of Alcohol:
3. Exercise Routine
Type of Exercise:
Frequency:

Emergency Contact Information	
Primary Emergency Contact:	Phone:
Healthcare Proxy/Power of Attorney:	Phone:
Parent/Legal Guardian (if applicable):	Phone:

Additional Information

Declaration
I acknowledge that the information in this questionnaire is accurate and complete to the best of my knowledge.
Patient Signature:
Name:
Date:

Medical Provider's Notes

Next Steps

Follow-up Date
Provider's Signature
Name: