

Medical Needs Form

Patient information				
Full name:				
Date of birth:	Age:	Gender:		
Address:	Contact number:			
Emergency contact name:				
Emergency contact number:	Relationship to patient:			
Medical history				
Do you have any chronic illnesses or medical conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list:			
Past surgeries or hospitalizations:				
Family medical history (e.g., heart disease, diabetes, etc.):				
Current medications				
Medication name	Dosage	Frequency		

Allergies	
Do you have any allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes please specify:
Lifestyle & habits	
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how often?
Do you consume alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how often?
Do you follow any specific diet? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe:
Do you exercise regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how often?
Insurance information	
Insurance provider:	
Policy number:	
Healthcare preferences:	
Preferred primary care physician:	
Preferred hospital/healthcare facility:	
Accessibility needs (if any):	

Consent and signature

I, _____, certify that the above information is accurate to the best of my knowledge. I consent to the use of this information for medical care and emergency purposes.

Patient signature:**Date:****Guardian/representative signature (if applicable):****Date:****For healthcare provider use only****Physician/provider name:****Signature:****Date:****Additional notes:**