MEDICAL HISTORY FORM

Patient Full Name: _____

Date of Birth: _____ Gender: _____

Address: _____

Phone Number: _____ Email: _____

Emergency Contact Information:

Full Name: _____

Relationship: _____ Phone Number: _____

General Health Questions:

Do you have any allergies? If yes, please list:

Have you had any surgeries or hospitalizations? If yes, please provide details:

Do you take any medications regularly? If yes, please list:

Do you have any chronic illnesses or conditions? If yes, please provide details:

Do you smoke or use tobacco products?

Do you consume alcohol? If yes, how frequently?

Have you ever been diagnosed with any of the following? (Circle all that apply): Hypertension, Diabetes, Heart Disease, Asthma, Cancer, Depression, Other:

Are you currently pregnant or breastfeeding?

Do you have any physical disabilities or limitations?

Have you had any recent significant weight changes?

Medical History - Please provide details if applicable:

Cardiovascular Disease: _____

Respiratory Problems: _____

Diabetes: _____

Kidney Disorders: _____

Liver Disorders: _____

Neurological Disorders: _____

Mental Health Conditions: _____

Cancer: _____

Infectious Diseases: _____

Other relevant medical conditions: _____

Family Medical History:

Heart Disease: _____

Diabetes: _____

Cancer: _____

Hypertension: _____

Stroke: _____

Other hereditary conditions: _____

Lifestyle and Social History:

Occupation: _____

Exercise frequency and type: _____

Dietary habits: _____

Alcohol consumption frequency: _____

Tobacco use: _____

Use of recreational drugs: _____

Sleep patterns: _____

Consent and Declaration:

I hereby declare that the information I have provided in this Medical History Form is true and correct to the best of my knowledge. I understand that providing false information may affect the quality of care and treatment I receive. I consent to the use of this information for medical assessment and treatment purposes in accordance with applicable Australian privacy laws and healthcare regulations.

PATIENT SIGNATURE

Signature: _____

Print Name: _____

Date: _____

HEALTHCARE PROVIDER SIGNATURE

Signature: _____

Print Name: _____

Date: _____