

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

HEALTHCARE PROVIDER SIGNATURE

Signature: _____

Signature: _____

Print Name: _____

Print Name: _____

Date: _____

Date: _____

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