Medical History Questionnaire

Personal Information

Full Name

Date of Birth

Gender

Phone Number

Email Address

Address

Emergency Contact

Name

Relationship

Phone Number

Medical History

Allergies

Current Medications

Past Illnesses or Hospitalizations

Past Surgeries

Chronic Conditions

Family Medical History

List any family medical conditions

Lifestyle

Do you smoke?

Do you drink alcohol?

Describe your exercise routine

Other Comments

Please add any additional information