# Medical History Questionnaire

*This form is used to collect a patient's medical history, current medications, allergies, and relevant health information to assist healthcare providers in delivering optimal care.*

## Patient Information

**Full Name:** {fullName}

**Date of Birth:** {dateOfBirth}

**Gender:** {gender}

**Phone Number:** {phone}

**Email Address:** {email}

**Emergency Contact Name:** {emergencyContactName}

**Emergency Contact Phone:** {emergencyContactPhone}

## Primary Care Provider

**Provider Name:** {providerName}

**Clinic Name:** {clinicName}

**Phone Number:** {providerPhone}

## Medical History

Check any conditions that apply to you:

{#medicalConditions}

* {condition}

{/medicalConditions}

**Other Medical Conditions (not listed above):**

{otherConditions}

## Surgeries and Hospitalizations

Please list any major surgeries or hospitalizations you have had:

{#surgeries}

* **{procedureName}** - {year} ({reason})

{/surgeries}

## Medications

Provide a list of all current prescription and non-prescription medications:

|  |  |  |
| --- | --- | --- |
| **Medication Name** | **Dosage** | **Frequency** |
| {#medications}{medicationName} | {dosage} | {frequency}{/medications} |

## Allergies

Please list any allergies, including medications, food, or environmental:

{#allergies}

* **{allergen}:** {reaction}

{/allergies}

{^allergies}

No known allergies.

{/allergies}

## Family Medical History

Indicate if any immediate family members have had the following conditions:

|  |  |  |
| --- | --- | --- |
| **Condition** | **Family Member** | **Details** |
| {#familyHistory}{condition} | {familyMember} | {details}{/familyHistory} |

## Lifestyle & Habits

**Do you smoke?** {smokeStatus}

**Do you consume alcohol?** {alcoholStatus}

**Do you use recreational drugs?** {drugUse}

**Exercise frequency:** {exerciseFrequency}

**Any dietary restrictions?** {dietaryRestrictions}

## Additional Information

**Any additional notes or concerns?**

{additionalNotes}