Free Fillable Medical History Form

Patient Details:

- **Name:** ____
- **Date of Birth:** ____
- **Phone Number:** _______________________________________
- **Address:** ____

Medical Information:

1. **Current Medications:**
   - ____
   - ____
2. **Known Allergies:**
   - ____
   - ____
3. **Chronic Conditions:**
   - ____
   - ____
4. **Previous Surgeries:**
   - ____
   - ____
5. **Family History:**
   - ____
   - ____
6. **Lifestyle and Habits:**
   - **Smoking: [ ] Yes [ ] No**
   - **Alcohol Use: [ ] Yes [ ] No**

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- **Exercise Frequency: ___________________________________**

Emergency Contact Information:

- **Contact Name: ____**
- **Relationship: ____**
- **Phone Number: ____**

Patient Authorization:

I certify that the above information is true and complete to the best of my knowledge.

Signature: ____

Date: ____

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