# New Patient Medical History Form

## Patient Information:

- **Full Name:** _____
- **Date of Birth:** _____
- **Gender:** _____
- **Phone Number:** _____
- **Address:** _____

## Medical Background:

1. **Medications Currently Taken:**
   - _____
   - _____
2. **Known Allergies:**
   - _____
   - _____
3. **Chronic Conditions or Past Illnesses:**
   - _____
   - _____
4. **Surgeries or Major Procedures:**
   - _____
   - _____
5. **Family Medical History (e.g., heart disease, diabetes):**
   - _____
   - _____
6. **Lifestyle Factors:**
   - **Smoking:** [ ] Yes [ ] No
   - **Alcohol Use:** [ ] Yes [ ] No

- **Exercise Routine: _____**

## Emergency Contact Information:

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

## Patient Declaration:

I affirm that the above information is accurate and complete.

**Patient Signature: _____**

**Date: _____**