Simple Medical History Form

Patient Information:

- **Full Name:** ____
- **Date of Birth:** ____
- **Gender:** ____
- **Contact Number:** ____
- **Address:** ____

Medical History:

1. **Current Medications:**
   - ____
   - ____
2. **Allergies:**
   - ____
   - ____
3. **Past Medical Conditions:**
   - ____
   - ____
4. **Surgeries:**
   - ____
   - ____
5. **Family Medical History:**
   - ____
   - ____
6. **Lifestyle:**
   - **Smoking:** [ ] Yes [ ] No
   - **Alcohol Consumption:** [ ] Yes [ ] No

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- Exercise: [ ] Regularly [ ] Occasionally [ ] Never

Emergency Contact:

- **Name:** ____
- **Relationship:** _______________________________________
- **Contact Number:** ____________________________________

Patient Signature: _____________________________________

Date: ____

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