Universal Health Record Form

Personal Information

- **Full Name: ____**
- **Date of Birth (MM/DD/YYYY): ____________________________**
- **Gender: ☐ Male ☐ Female ☐ Other**
- **Contact Number: ______________________________________**
- **Email Address: ____**

Medical History

Health Condition	Yes ☐	No ☐	Notes
High Blood Pressure			
Kidney Problems			
Liver Disease			
Anxiety/Depression			
Surgeries in the Past 5 Years			
Medications Currently Taken			
Hospitalizations in Last Year			

Emergency Contact

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

Checkbox

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- ☐ **I confirm that the above information is accurate to the best of my knowledge.**

Signature: ____

Date: ____

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