**Medical Health Questionnaire Template**

**Personal Details  
Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical History  
Do you have any existing medical conditions? [ ] Yes [ ] No  
If yes, list them: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Are you currently taking any medications? [ ] Yes [ ] No  
If yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Recent Symptoms  
Have you recently experienced any of the following?**

* **Fatigue [ ] Yes [ ] No**
* **Headaches [ ] Yes [ ] No**
* **Chest Pain [ ] Yes [ ] No**

**Lifestyle & Wellness  
Do you exercise regularly? [ ] Yes [ ] No  
Do you have any dietary restrictions? [ ] Yes [ ] No**

**Family Medical History  
Does anyone in your family have a history of heart disease, diabetes, or cancer? [ ] Yes [ ] No  
If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Declaration  
I declare that all information provided is true and complete.  
Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**