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: _____