Basic Medical History Form

Instructions: Please answer the questions below. If you don't understand a question, ask for help.

Personal Information

1. **First Name:** _____
2. **Last Name:** _____
3. **Date of Birth (MM/DD/YYYY):** _____
4. **Gender:** □ Male □ Female □ Other: _____
5. **Phone Number:** _____
6. **Address:** _____

Emergency Contact

1. **Name:** _____
2. **Phone Number:** _____
3. **Relationship to You:** _____

Medical History

1. **Do you have any allergies?** □ Yes □ No
   If yes, what are you allergic to? _____
2. **Do you take any medications?** □ Yes □ No
   If yes, list them here: _____
3. **Do you have any health problems?** □ Yes □ No
   If yes, what are they? _____
4. **Have you had any surgeries?** □ Yes □ No
   If yes, explain: _____
5. **Do you smoke?** □ Yes □ No
6. **Do you drink alcohol?** □ Yes □ No

Family Medical History

1. **Does anyone in your family have health problems?** □ Yes □ No
   If yes, explain: _____

Current Symptoms

1. **Do you have pain now?** □ Yes □ No
   If yes, where is the pain? _____
2. **Do you feel sick today?** □ Yes □ No
   If yes, what are your symptoms? _____

Signature

1. **Today's Date:** _____
2. **Signature:** _____