Medical Needs Form

PERSONAL INFORMATION

Full name: _____ Date of birth: _____ dd / mm / yyyy

Age: _____ Gender: _____

Address:

Contact number: _____

EMERGENCY CONTACT

Name: _____ Relationship to patient: _____

Contact number: _____

MEDICAL HISTORY

Do you have any chronic illnesses or medical conditions?

◯ Yes ◯ No

If yes, please list:

Past surgeries or hospitalizations:

Family medical history (e.g., heart disease, diabetes, etc.):

CURRENT MEDICATIONS

1. Medication name: _____ Dosage: _____

Frequency: _____ 2. Medication name: _____

Dosage: _____ Frequency: _____

3. Medication name: _____ Dosage: _____

Frequency: _____ 4. Medication name: _____

Dosage: _____ Frequency: _____

5. Medication name: _____ Dosage: _____

Frequency: _____

ALLERGIES

Do you have any allergies?

◯ Yes ◯ No

If yes, please specify:

LIFESTYLE & HABITS

Do you smoke?

◯ Yes ◯ No

If yes, how often?

Do you consume alcohol?

◯ Yes ◯ No

If yes, how often?

Do you follow any specific diet?

◯ Yes ◯ No

If yes, please describe:

Do you exercise regularly?

◯ Yes ◯ No

If yes, how often?

INSURANCE INFORMATION

Insurance provider: _____

Policy number: _____

Healthcare preferences: _____

Preferred primary care physician: _____

Preferred hospital/healthcare facility: _____

Accessibility needs (if any): _____

CONSENT AND SIGNATURE

Fill up the following:

Patient signature:
Date: _____ dd / mm / yyyy

Guardian/representative signature (if applicable):
Date: _____ dd / mm / yyyy

FOR HEALTHCARE PROVIDER USE ONLY

Physician/provider name: _____

Signature:
Date: _____ dd / mm / yyyy

Additional notes: