

Comprehensive Medical History Questionnaire

Please complete this form accurately to provide essential information for your medical care. All information will be kept confidential.

1. What is your primary reason for today's visit or consultation?

2. Date of Birth

Example: January 7, 2019

3. Biological Sex

Mark only one oval.

- Male
- Female
- Prefer not to disclose

4. Do you have any known allergies (medications, foods, environmental)?

Check all that apply.

- No known allergies
- Medication Allergies (e.g., Penicillin)
- Food Allergies (e.g., Peanuts, Shellfish)
- Environmental Allergies (e.g., Pollen, Dust)
- Latex Allergy
- Other (Please specify below)

5. If you selected 'Medication Allergies' or 'Other', please list the specific allergens and your reaction(s).

6. Please list all prescription and over-the-counter medications you currently take, including supplements and vitamins (Name, Dose, Frequency).

7. Have you been diagnosed with any of the following Chronic Conditions? (Select all that apply)

Check all that apply.

- Hypertension (High Blood Pressure)
- Diabetes (Type 1 or Type 2)
- Asthma or COPD
- Heart Disease (e.g., Angina, History of Heart Attack)
- Cancer (Specify type below)
- Thyroid Disorder
- Autoimmune Disorder (e.g., Lupus, Rheumatoid Arthritis)
- Kidney Disease
- Epilepsy/Seizure Disorder
- None of the above

8. If you selected 'Cancer', please specify the type and approximate year of diagnosis.

9. Have you had any major surgeries or hospitalizations in the past? (Please specify procedure/reason and year)

10. Please indicate your current or past smoking status:

Mark only one oval.

- Never Smoker
- Former Smoker (Quit more than 1 year ago)
- Current Smoker (Daily)
- Current Smoker (Occasional)

11. On average, how many standard alcoholic drinks do you consume per week?

12. Do any immediate family members (Parents, Siblings) have a history of the following conditions? (Select the severity for each relative)

Mark only one oval per row.

	None	Mother/Maternal Side	Father/Paternal Side	Both Sides
Heart Attack/Stroke before age 55	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cancer (specify type if known)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Osteoporosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Autoimmune Disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

13. How would you rate your overall perception of your current health?

Mark only one oval.

1 2 3 4 5 6 7 8 9 10

Poo Excellent

14. When was your last comprehensive physical examination?

Example: January 7, 2019

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