Health History Form

Section 1: Personal Information

- **Full Name:** _____
- **Date of Birth:** _____
- **Gender:** (☑ Male / ☑ Female)
- **Nationality:** _____
- **ID/Passport Number:** _____
- **Full Address:** _____

- **Phone Number:** _____
- **Email Address:** _____

Section 2: Medical History

- **Do you have any chronic illnesses?** (☑ Yes / ☑ No) If yes, specify:
  _____
- **Do you have any allergies?** (☑ Yes / ☑ No) If yes, specify:
  _____
- **Current Medications:** _____
- **Have you had any previous surgeries?** (☑ Yes / ☑ No) If yes, specify:
  _____
- **Do you have a family history of any illnesses?** (☑ Yes / ☑ No) If yes, specify:
  _____

Section 3: Lifestyle Information

- **Do you smoke?** (☑ Yes / ☑ No) If yes, how many per day?
  _____

- **Do you consume alcohol?** (☑ Yes / ☑ No) If yes, how often? _____
- **Do you exercise regularly?** (☑ Yes / ☑ No) If yes, what type of exercise? _____

Section 4: Emergency Contact

- **Emergency Contact Name:** _____
- **Relationship to Patient:** _____
- **Phone Number:** _____

Section 5: Consent and Signatures

I hereby declare that all the information provided above is accurate and I consent to the use of my data in accordance with privacy and healthcare policies.

- **Patient/Guardian Signature:** _____
- **Date:** _____