Patient Medical Onboarding Form

Personal Information

1. Full Name: Rudra

2. Date of Birth (DD/MM/YYYY): 23 October

3. Gender: Male

4. Phone Number: 8020299182

5. Email Address:

6. Residential Address:

7. Emergency Contact Name & Number:

Medical History

8. Do you have any known allergies? (e.g., food, medications, environment)

9. Are you currently taking any medications? If yes, please list them.

10. Have you had any major surgeries in the past?

11. Do you have any chronic conditions? (e.g., diabetes, hypertension, asthma)

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12. Have you ever been hospitalized? If yes, when and why?

Lifestyle & Habits

13. Do you smoke or use tobacco products?

14. Do you consume alcohol? If yes, how often?

15. Do you engage in regular physical activity or exercise?

16. How would you rate your stress levels on a scale of 1 to 10?

Family Medical History

17. Does anyone in your family have a history of heart disease?

18. Is there any family history of cancer, diabetes, or mental health conditions?

Other

19. What brings you in today? Please describe your current symptoms or concerns.

20. Is there anything else you'd like your healthcare provider to know?

Signature: _____ Date: _____