Medical History Questionnaire for Hospitalization

Patient Information

Full Name

Date of Birth

Gender Select

Phone Number

Email Address

Home Address

Emergency Contact

Name

Relationship

Phone Number

Hospitalization Details

Reason for Hospitalization

Proposed Admission Date

Attending Physician (if known)

Medical History

Do you have (or had) any of the following? (Check all that apply)

☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Asthma ☐ Stroke ☐ Cancer ☐ Allergies ☐ None

Other illnesses or conditions

Current Medications

Drug/Food Allergies

Previous Hospitalizations/Surgeries (with year)

Lifestyle Information

Do you smoke? Select

Do you consume alcohol? Select

Physical Activity/Exercise Level Select

Family Medical History

Family history of major diseases (eg. diabetes, cancer, heart disease, etc)

Other Information

Please provide any other relevant information

Patient Signature

Date