Pre-Admission Assessment Questionnaire

Personal Information

Full Name

Date of Birth

Gender

Select

Contact Number

Home Address

Medical History

Do you have any of the following conditions?

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Asthma ☐ None

Do you have allergies? If yes, please list them.

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

Surgical History

Have you had any previous surgeries? If yes, please specify.

Reason for Admission

Other Information

Emergency Contact Name

Emergency Contact Phone

Additional Information