Personal Health History Form
Critical Illness Assessment

Personal Information

Full Name

Date of Birth

Gender

Select

Contact Number

Email Address

Address

Medical History

Have you ever been diagnosed with a critical illness?

Select

If yes, diagnosis date

If yes, provide details (Type of Illness, Treatment, etc.)

Other Relevant Medical History

Family History

Family history of critical illness?

- [ ] Heart Disease
- [ ] Cancer
- [ ] Stroke
- [ ] None

If yes, please specify relationship and diagnosis

Lifestyle Information

Do you smoke?

Select

Do you consume alcohol?

Select

Physical Activity Level

Select

Declaration & Signature

I declare that the information provided is true to the best of my knowledge.

Signature

Date