Standard Medical History Questionnaire

Personal Details

Full Name

Date of Birth

Gender

Select

Email Address

Phone Number

Address

Medical History

1. Height (cm)

Weight (kg)

2. Have you ever been diagnosed or treated for any of the following?

Heart Disease Diabetes Stroke Cancer Lung Disease Liver Disease

Kidney Disease None

3. Are you currently taking any prescription medication?

Yes No

If yes, please specify

4. Do you smoke tobacco?

Yes No

If yes, how many per day?

5. Do you consume alcohol?

Yes No

If yes, average amount per week

6. Any surgery or hospitalization in the past 5 years?

Yes No

If yes, please provide details

7. Has any of your biological parents or siblings been diagnosed with a major illness (e.g., heart attack, cancer) before age 60?

Yes No

If yes, state the relationship and illness

8. Are there any other medical conditions or details to disclose?

Declaration

I hereby declare that the information provided above is true and complete to the best of my knowledge.

Signature

Date