# Medical History Form for Appointment

**Please fill out this form accurately to help the doctor understand your medical history**

**1. Personal Information**

- Full Name: _____
- Date of Birth (MM/DD/YYYY): _____ Age:_____ Sex:_____
- Contact Email: _____
- Phone Number: _____

**2. Medical History**

- Primary Concern for This Appointment:

  _____
- Current Medications:
- (List all medications, including over-the-counter and supplements)

  _____
- Allergies:
- (Include medications, food, or other substances)

  _____
- Past Medical Conditions or Surgeries:
- (List any significant health issues or surgeries in the past)

  _____
- If taking medicine or any past medical report (Like MRI Scan, USG whole abdomen-Please attach)

**Last menstrual cycle**_____

**Any abortion: □ YES □ NO**

**3. Lifestyle Information**

- **Do You Smoke?**
  **□ Yes**
  **□ No**
- **Do You Consume Alcohol?**
  **□ Yes**
  **□ No**
- **Physical Activity Level:**
  **□ Sedentary**
  **□ Moderate**
  **□ Active**

**4. Additional Notes**

- **Anything Else You'd Like the Doctor to Know:**_____

_____ _____

***Patient's Signature*** ***Date***

***Please complete and return this form before your scheduled appointment for a better consultation experience.***