

Medical History and Evaluation Form

Please complete all sections of this form. This document is intended for print and manual completion or physical record-keeping.

1. Patient Information

Full Name:	<input type="text"/>	Date of Birth:	<input type="text" value="MM/DD/YYYY"/>
Gender:	<input type="text" value="Male / Female / Other"/>	Phone Number:	<input type="text"/>
Address:	<input type="text"/>		
Emergency Contact:	<input type="text"/>	Contact Phone:	<input type="text"/>

2. Medical History

Are you currently taking any prescription medications?	<input type="text" value="If yes, please list..."/>
Do you have any known food or drug allergies?	<input type="text" value="If yes, please list..."/>
Have you had any major surgeries or hospitalizations?	<input type="text" value="Please list procedures and approximate dates..."/>
Do you have a history of chronic conditions? (e.g., Diabetes, Hypertension)	<input type="text" value="If yes, please specify..."/>

3. Social and Family History

Do you use tobacco products? (Yes / No)	<input type="text"/>
Do you consume alcohol? (Yes / No / Occasionally)	<input type="text"/>
Family medical history of heart disease or cancer? (Yes / No)	<input type="text" value="If yes, specify family member..."/>

4. Clinical Evaluation (To be completed by Medical Staff)

Blood Pressure:	<input type="text"/> mmHg	Heart Rate:	<input type="text"/> bpm
Temperature:	<input type="text"/> Â°F	Oxygen Saturation:	<input type="text"/> % SpO2
Height:	<input type="text"/> inches	Weight:	<input type="text"/> lbs
General Appearance:	<input type="text"/>		
Clinical Notes:	<input type="text"/>		
Diagnosis / Assessment:	<input type="text"/>		
Plan / Recommendations:	<input type="text"/>		

Patient Signature

Date

Evaluator Name & Title

Evaluator Signature