

EMS Medical History Form



Patient Information

Full Name: _____
Date of Birth (DOB): _____
Address: _____
Phone Number: _____
Email Address: _____

Emergency Contact Information

Name: _____
Relationship: _____
Phone Number: _____

Medical History

Please answer the following questions accurately. This information is essential for your safety and to determine your suitability for EMS treatments.

Do you have any of the following conditions? (Tick all that apply or put Yes or No):

Have you experienced any of the following symptoms or issues?

Are you currently taking any medications, supplements, or herbal remedies?

Do you have any allergies (medications, adhesives, latex, etc.)?

Have you undergone any recent medical or aesthetic treatments (e.g., surgery, laser, injections)?

Do you have a history of weight fluctuations or significant recent weight changes?

Do you exercise regularly?

Are you following any specific dietary plans or restrictions?

Lifestyle Factors

Do you smoke?

Do you consume alcohol?

How much water do you drink daily? _____

Consent and Acknowledgement

I confirm that the information provided above is accurate to the best of my knowledge. I understand that withholding any medical information may increase the risk of complications during or after EMS treatments. I agree to inform my practitioner of any changes in my health or medications prior to each session.

Patient Signature: _____

Date: _____

Practitioner Signature: _____

Date: _____