**MEDICAL HISTORY QUESTIONAIRE**
***MARK F. MORRISON, M.D.***
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Patient Name _____ Date _____

Age _____ Referred by _____ Relationship _____

## MEDICAL HISTORY

1. What is the reason you are seeing the Doctor today? _____
2. How long have you had this problem in the past?_____
3. List all medication you are taking. _____

_____

_____

4. Are you allergic to any medicines? _____

## PAST HISTORY

1. List all operations, injuries and hospitalizations. _____

_____

_____

2. List all medical problems. _____

## PERSONAL & OB/GYN HISTORY

1. Married Divorced Widowed Single
2. Date of last menstrual period _____
3. Number of pregnancies _____ Number of living children _____ Miscarriages ____ Abortions _____
4. Are you taking birth control pills? Yes No
5. Do you use contraception? Yes No If yes what type?_____
6. Have you had a Hysterectomy? Yes No Do you have your Ovaries? Yes No
7. Do you have difficulties with your periods? Yes No
   Pain _____ Irregular _____ Excess bleeding _____ Prolonged bleeding ____ Bleeding between periods 8.

Do you smoke? Yes No Do you drink alcohol? Yes No

## FAMILY HISTORY

Any Family member with Cancer: Yes No If yes Whom? _____
Uterine _____ Cervical _____ Breast_____ Ovarian_____

Any other issues you would like Dr. Morrison to know about? _____

_____

_____