MEDICAL HISTORY QUESTIONAIRE

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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. ______________________________

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4. Are you allergic to any medicines? ______________________________

PAST HISTORY

1. List all operations, injuries and hospitalizations. ______________________________

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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? ______________________________

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