MEDICAL HISTORY QUESTIONAIRE

Name _____ Date _____

Age _____Date of Birth_____Referred by _____

MEDICAL HISTORY

1. What is the reason you are seeing the Doctor today? _____

2. How long have you had this problem?_____

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 smoke? Yes No Do you drink alcohol? Yes No

8. History of Blood clots Yes No

9. Date of Last Pap Smear _____ Mammogram_____

Date of Last Colonoscopy _____

FAMILY HISTORY: Anyone with?

Breast Cancer? Whom_____Age_____

Uterine Cancer? Whom_____Age_____

Ovarian Cancer? Whom _____Age_____

Cervical Cancer? Whom _____Age_____

Any other issues you would like the Provider to know about? _____

_____

_____