



**Markle  
Medical  
Center**

**MEDICAL HISTORY QUESTIONNAIRE**

Name \_\_\_\_\_ Date \_\_\_\_\_ Marital Status: S M D W  
 Occupation \_\_\_\_\_ Age \_\_\_\_\_ Prev. MMC Patient? \_\_\_\_\_

Allergies: \_\_\_\_\_

Drug Intolerance: \_\_\_\_\_

Please list your present health problem(s) if any:

Please list any surgeries you have had:

Please list your dependent(s) name(s) and birthdate(s):

Does anyone in your family have (please indicate how related):

Diabetes? \_\_\_\_\_  
 Stroke? \_\_\_\_\_  
 Inherited disease? \_\_\_\_\_

Heart Disease? \_\_\_\_\_  
 Tuberculosis? \_\_\_\_\_  
 High blood pressure? \_\_\_\_\_

Do you smoke? ( ) Yes ( ) No How much per day?  
 Do you drink alcohol? ( ) Yes ( ) No

Please list any medications you are currently taking:

**Female patients only:**

Age when periods began: \_\_\_\_\_ When was your last menstrual period? \_\_\_\_\_  
 Do you take birth control pills? \_\_\_\_\_ How many days apart are your periods? \_\_\_\_\_  
 How long do your periods last? \_\_\_\_\_ Do you have bleeding between periods? \_\_\_\_\_  
 Are you having any problems with your periods currently? \_\_\_\_\_