MARGARET MARY HEALTH

P.O. Box 226 • 321 Mitchell Avenue
Batesville, IN 47006
Phone: 812.934.6624

MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

PAST HISTORY

Medications

Drug	Dose	#	Prescribed By:	Date Prescribed:	Reason:

Allergies

Allergies	Type	Response

Past Major Illnesses, Surgeries and Injuries

Date	Event

General Health

Do you currently feel healthy? ❒ Yes ❒ No
Is your appetite good? ❒ Yes ❒ No
Have you lost weight? ❒ Yes ❒ No If yes, how many pounds? _____
Are you unusually fatigued? ❒ Yes ❒ No
Do you have a fever? ❒ Yes ❒ No If yes, what is the temperature? _____
Do you have night sweats? ❒ Yes ❒ No

Social History

Marital Status? ❒ Single ❒ Married ❒ Divorced ❒ Separated ❒ Widowed
Do you have children? ❒ Yes ❒ No If yes, how many? _____
Do you live alone? ❒ Yes ❒ No
Do you drive a car? ❒ Yes ❒ No
Past or present occupation? _____
Employment Status? ❒ Full-Time ❒ Part-Time ❒ Unemployed ❒ Homemaker ❒ Retired
❒ On Disability Leave

Social History

Spouse's Employer? _____

Do you drink alcohol? ❒ Yes ❒ No

Do you use recreational drugs? ❒ Yes ❒ No

Do you smoke? ❒ Yes ❒ No ❒ Never If yes, what age did you stop? _____ Year Quit: _____

Health History

Do you presently have any problems in the below areas?

Skin, rash ❒ Yes ❒ No If yes, explain: _____

Head, eyes, ears, nose, mouth or throat ❒ Yes ❒ No If yes, explain: _____

Lungs, breathing ❒ Yes ❒ No If yes, explain: _____

Heart/Blood vessels ❒ Yes ❒ No If yes, explain: _____

Stomach/Intestines ❒ Yes ❒ No If yes, explain: _____

Genitals/Kidneys/Bladder ❒ Yes ❒ No If yes, explain: _____

Bones, joints or muscles ❒ Yes ❒ No If yes, explain: _____

Nerves ❒ Yes ❒ No If yes, explain: _____

Lymphnodes/Swelling ❒ Yes ❒ No If yes, explain: _____

Blood ❒ Yes ❒ No If yes, explain: _____

Mental Health/Psychiatric ❒ Yes ❒ No If yes, explain: _____

Family History (Please check all that apply and indicate the relative(s).)

❒ Blindness Relationship: _____

❒ Cancer (Type: _____) Relationship: _____

❒ Arthritis Relationship: _____

❒ Heart Attacks Relationship: _____

❒ High Blood Pressure Relationship: _____

❒ Diabetes Relationship: _____

❒ Kidney Disease Relationship: _____

❒ Stroke Relationship: _____

❒ Thyroid Disease Relationship: _____

❒ Other: _____ Relationship: _____

If any of your family members have had cancer, please list where it started:

❒ Mother Location: _____

❒ Father Location: _____

❒ Sisters Location: _____

❒ Brothers Location: _____

❒ Other Location: _____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____