Evans Gynecology
Patient History Form

Today's Date ______________________________

Name ______________________________ Date of Birth ______________
Reason for visit ______________________________
Primary Physician ______________________________

MEDICAL HISTORY
Please mark any condition you currently have or have had in the past.

Breast	Yes	No	Infectious Disease	Yes	No	Personal History of Cancer	Yes	No
Breast cancer			Chickenpox			Colon		
Breast pain			HIV/AIDS			Ovary		
Fibrocystic breast disease			Mononucleosis			Skin		
Other:			Tuberculosis			Uterine		
Cardiovascular	**Yes**	**No**	Other:			Other:		
Heart attack			**Injuries**	**Yes**	**No**	**Psychiatric**	**Yes**	**No**
High cholesterol			Hip fractures			Anxiety disorder		
Hypertension			Motor vehicle accident			Depression		
Mitral valve prolapse			Pelvic fractures			Eating Disorder		
Other:			Other:			Memory Loss		
Gastrointestinal	**Yes**	**No**	**Musculoskeletal**	**Yes**	**No**	Other:		
Bowel problems			Arthritis/joint pain			**Respiratory**	**Yes**	**No**
Gallbladder disease			Back pain			Asthma		
Hepatitis/Jaundice			Osteoporosis			Bronchitis/pneumonia		
Reflux disease/hiatal hernia			Rheumatoid arthritis			Emphysema/COPD		
Ulcer disease			Systemic lupus			Other:		
Other:			Other:			**Urologic**	**Yes**	**No**
Hematologic	**Yes**	**No**	**Neurologic**	**Yes**	**No**	Incontinence		
Anemia			Migraines			Kidney stones		
Blood transfusion			Seizures			Painful urination		
Clots in legs, lungs, or pelvis			Strokes			Urinary frequency		
Factor V Leiden			Other:			Urinary urgency		
Sickle cell trait/disease						Other:		
Von Willebrand disease						**Please list any conditions not shown**		
Other:								

SURGICAL HISTORY

Surgery	Date	Surgery	Date

OBSTETRIC HISTORY	
Total pregnancies	Premature deliveries (less than 37 weeks) ☐ Yes ☐ No
Miscarriages ☐ Yes (how many?) ☐ No	Total full term births (more than 37 weeks)
Pregnancy terminated ☐ Yes ☐ No	Number of living children?

Birth Date	Weeks pregnant	Baby's Sex	Weight	Type of delivery (vaginal or cesarean)	Complications
1.					
2.					
3.					
4.					
5.					

GYNECOLOGIC/MENSTRUAL HISTORY			
Date of last menstrual period	**Other**	**Yes**	**No**
Days of cycles duration	Abnormal Pap Smear		
Discomfort during cycle ☐ Minimal ☐ Moderate ☐Severe	Cancer/pre-cancer cervix		
Cycle interval	Endometriosis		
Age of first menstrual period	Fibroid tumors		
Birth control method	History of Infertility		
Menopausal ☐ Yes ☐ No	Ovarian cysts		
	Other:		
Sexually active ☐ Yes ☐ No If Yes, any pain with intercourse ☐ Yes ☐ No			
History of sexually transmitted disease ☐ Yes ☐ No If Yes, please explain:			

MEDICATIONS YOU ARE TAKING
Please include hormones, vitamins, herbs, and non-prescription medication

Drug Name	Dosage	Physician	Drug Name	Dosage	Physician

ALLERGIES
Do you have any drug allergies? ☐ Yes ☐ No If yes, please list drug name and type of reaction:
Are you allergic to iodine/shellfish ☐ Yes ☐ No
Have you/family member ever had a reaction to anesthesia ☐ Yes ☐ No If Yes, please describe:

SOCIAL HISTORY
Martial status ☐ Single ☐ Married ☐ Living with partner ☐ Divorced ☐ Widowed
Occupation
Do you exercise ☐ Yes ☐ No If Yes, # of times weekly
Have you been sexually abused, threatened, or hurt by anyone? ☐ Yes ☐ No
Smoker ☐ Never ☐ Yes ☐ Quit If yes, how many per day?
Alcohol consumption ☐ Never ☐ Minimal ☐ Moderate ☐ Heavy ☐ Quit
Recreational drug use ☐ Yes ☐ No If Yes, please explain
Cultural/religious preferences that would affect your care ☐ Yes ☐ No If Yes, explain

FAMILY HISTORY		
Relative	**Current health problems**	**If deceased, cause of death and age at death**
Mother		
Father		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		
Sibling (Sister/Brother)		
Sibling (Sister/Brother)		

HEALTH MAINTENANCE

Please provide dates for the following vaccines or tests

Pneumonia __________ Gardasil __________ Influenza __________ Tetanus __________ Shingles __________

Date of last colonoscopy __________ Concerning findings ☐ Yes ☐ No If Yes, explain __________

Last mammogram __________ Bone density study __________ PAP/Pelvic exam __________