Evans	Gynecolog	y
Patien	t History	Form

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			Strokes			Urinary frequency		
pelvis								
Factor V Leiden			Other:			Urinary urgency		
Sickle cell trait/disease						Other:		
Von Willebrand disease						Please list any conditions	s not sho	wn
Other:								

SURGICAL HISTORY					
Surgery	Date	Surgery	Date		

			OBSTET	RIC HISTORY				
Total pregnancies			Premature deliveries	Premature deliveries (less than 37 weeks) ☐ Yes ☐ No				
Miscarriages □ Yo	es (how many?)] No	Total full term births	Total full term births (more than 37 weeks)			
Pregnancy terminat					Number of living children?			
Birth Date	Weeks	Baby's	Weight					
	pregnant	Sex	,, ergine	(vaginal or cesarean)				
1.	pregnuit	2012		(vuginur or cosur cum)				
2.								
3.								
4.								
5.								
J.			<u> </u>					
		CVNECC)LOGIC/I	MENSTRUAL HISTOR	V			
Date of last menstr		GINEC	<u> </u>)ther	Yes	No	
Days of cycles dura				Abnormal Pap Smear		1 03	110	
Discomfort during		□ Moder	ate □Seve					
Cycle interval	cycle in ivinimai	I WIOGCI	ate Eseve	Endometriosis	IVIX			
Age of first menstr	ual period			Fibroid tumors				
Birth control metho				History of Infertility				
Menopausal ☐ Yes				Ovarian cysts				
Wichopausai 🗀 Tes	, <u> </u>			Other:				
Sexually active □	Ves □ No If V	ec any na	in with int	ercourse Yes No		_		
History of sexually				credurse in res in the				
		ic 🗀 Tes	LI NO					
ii i es, pieuse expit	*1111.	If Yes, please explain:						
MEDICATIONS VOLLADE TAIZING								
		MEDI	CATION	S YOU ARE TAKING				
	Please include			S YOU ARE TAKING . herbs, and non-prescri	otion medication			
Drug Name	Please include Dosage	normones		S YOU ARE TAKING , herbs, and non-prescri Drug Name	ption medication Dosage	Physicia	ın	
Drug Name		normones	, vitamins	, herbs, and non-prescri		Physicia	ın	
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	Dosage	normones	, vitamins hysician	, herbs, and non-prescri Drug Name		Physicia	nn	
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Do you have any di If yes, please list di	Dosage rug allergies? □ Y rug name and type	es \(\square\) No of reactio	, vitamins hysician AL n:	, herbs, and non-prescri Drug Name		Physicia	nn	
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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							
	Gardasil Influenza	Tetanus Shingles					
Date of last colonoscopy	Concerning findings □ Yes [□ No If Yes, explain					
Last mammogram	Bone density study	PAP/Pelvic exam					