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
Breast cancer		
Breast pain		
Fibrocystic breast disease		
Other:		
Cardiovascular	**Yes**	**No**
Heart attack		
High cholesterol		
Hypertension		
Mitral valve prolapse		
Other:		
Gastrointestinal	**Yes**	**No**
Bowel problems		
Gallbladder disease		
Hepatitis/Jaundice		
Reflux disease/hiatal hernia		
Ulcer disease		
Other:		
Hematologic	**Yes**	**No**
Anemia		
Blood transfusion		
Clots in legs, lungs, or pelvis		
Factor V Leiden		
Sickle cell trait/disease		
Von Willebrand disease		
Other:		

Infectious Disease	Yes	No
Chickenpox		
HIV/AIDS		
Mononucleosis		
Tuberculosis		
Other:		
Injuries	**Yes**	**No**
Hip fractures		
Motor vehicle accident		
Pelvic fractures		
Other:		
Musculoskeletal	**Yes**	**No**
Arthritis/joint pain		
Back pain		
Osteoporosis		
Rheumatoid arthritis		
Systemic lupus		
Other:		
Neurologic	**Yes**	**No**
Migraines		
Seizures		
Strokes		
Other:		

Personal History of Cancer	Yes	No
Colon		
Ovary		
Skin		
Uterine		
Other:		
Psychiatric	**Yes**	**No**
Anxiety disorder		
Depression		
Eating Disorder		
Memory Loss		
Other:		
Respiratory	**Yes**	**No**
Asthma		
Bronchitis/pneumonia		
Emphysema/COPD		
Other:		
Urologic	**Yes**	**No**
Incontinence		
Kidney stones		
Painful urination		
Urinary frequency		
Urinary urgency		
Other:		
Please list any conditions not shown		

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

GYNECOLOGIC/MENSTRUAL HISTORY

	Other	Yes	No
Date of last menstrual period			
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		
Sibling		

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 _____