Grace G. Evins, MD
Medical History Form

Name________________________ Date of Birth ____________ Date ____________
Family Doctor ________________________ Other Doctors ________________________
If you are a new patient, whom may we thank for referring you to our practice? ____________
Are you transferring care from another doctor, if so, from whom? ____________
What is your main reason for your visit today? ____________
What is your preferred pharmacy (prescriptions will be sent to your pharmacy electronically)____________
Medication allergies ____ ____________

General History

Please **circle** any of the following that apply to you:

High blood pressure	Stroke	Cancer	Ulcers
Heart disease	Blood clots	Breast	Irritable bowel syndrome
Heart attack	Bleeding disorder	Colon	Hepatitis
Heart murmur	Anemia	Ovarian	Migraines
Rheumatic fever	Asthma	Uterine	Seizure disorder
High cholesterol	Chronic lung disease	Other________	Osteoporosis
Diabetes	Tuberculosis	Depression	Arthritis
Thyroid Disease	Kidney Disease	Anxiety	GERD
Sleep disruption/insomnia			

Other ____

Physical or sexual abuse, past or present, can create serious physical or emotional problems for women. If this is an issue you would like to discuss, please indicate with a checkmark here_______

Surgical History

Please **circle** any of the following that apply to you:

Hysterectomy	C-section _______times
Vaginal abdominal	Tubes tied
Ovaries removal	Breast surgery
Left right both	Hernia repair
Ovarian cyst removed	Thyroid surgery

OB History

# of pregnancies ____________
full term births ____________
#abortions/miscarriages ____________
children living ____________

Gynecologic History

Age at your first period ____ years
Period occurs every ____ days and last ____ days
Periods are: regular irregular

Date of last menstrual period. ____________
Birth control method ____________
Date of last pap smear ____________
Was your pap normal ____________

Please **circle** any of the following that apply to you:

Heavy periods	Genital warts	Breast problems	Painful sex
Severe cramping	Gonorrhea	Pelvic inflammatory disease	Hot flashes
Fibroids	Chlamydia	Tubal pregnancy	Night sweats
Ovarian cysts	Herpes	Pelvic pain	Bleeding after menopause
Abnormal pap smear	Other sexually transmitted	Endometriosis	Urine leakage
Cryotherapy/LEEP	disease ____________	Infertility	Vaginal dryness
Memory loss	Decreased Libido		

Brief sexual symptom checklist

1. Are you satisfied with your sexual function ______Yes ______No (If no, please continue)
2. How long have you been dissatisfied with your sexual function? ____________
3. The problem(s) with your sexual function is: (mark one or more)
   a. Problems with little or no interest in sex
   b. Problems with decreased genital sensation (feeling)
   c. Problems with decreased vaginal lubrication (dryness)
   d. Problems reaching orgasm
   e. Problems with pain during sex
   f. Other ____________
4. Which problem (in question 3) is most bothersome? **Circle** a b c d e

5. Would you like to talk about it with your health care provider? ______Yes ______No

MEDICATIONS

Please include dose and frequency, including over the counter medications, vitamins, supplements and herbals

______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________

FAMILY HISTORY

Please include cancer, heart disease, diabetes, high blood pressure, blood clots and any other significant family history:

Mother: ______________________ Father: ______________________

Grandparents: ______________________ Sisters/Brothers: ______________________

______________________ ______________________

______________________ ______________________

SOCIAL HISTORY

Please **circle**: Single Married Divorced Widowed Same-sex relationship

Tobacco: None_____ Former smoker_____ Current smoker_____ _____packs per day

Alcohol: None_____ Socially_____ Other_______________ Amount______drinks per day

Drug Use: None_____ Former use_____ Other______________________

Occupation:______________________ Sexually active: Yes_____ No_____

Preventive Health History

Are your immunizations up-to-date?	Yes _____	No_____
Have you had the Hepatitis B vaccination series?	Yes _____	No_____
Have you had chicken pox or received the varicella vaccine?	Yes _____	No_____
Have you had a tetanus booster in the past 10 years?	Yes _____	No_____
Do you take calcium and vitamin D for your bones?	Yes _____	No_____
Do you take folic acid to prevent birth defects if you get pregnant?	Yes _____	No_____
Do you do self breast examinations?	Yes _____	No_____
Did you complete the Gardasil (HPV vaccine) series?	Yes _____	No_____

Last mammogram ______________________

Last colonoscopy ______________________

Last bone density ______________________

Last diabetes screening ______________________

Last cholesterol screening ______________________

Last thyroid screening ______________________

Last pneumonia shot ______________________

Are you in need of any vaccination updates, please indicate which ones here ______________________

Review of Systems

Please **circle** any of the following that apply to you:

Constitutional: Fever Weight gain Weight loss Fatigue

Integumentary: Change in moles Rashes Skin lesions

Breasts: Lumps Nipple discharge Skin change Abnormal mammogram

Cardiovascular: Chest pain Swelling Valve disorders

Gastrointestinal: Nausea Vomiting Bloating Diarrhea Constipation Blood in stool Black or tarry stool

Genitourinary: Burning or pain with urination Frequency Urgency Blood in urine Vaginal discharge Vaginal odor

Hematologic/Lymphatic: Blood clots Swollen lymph nodes Bruising easily

Endocrine: Excessive thirst Excessive hunger Excessive urination Hot flushes Cold intolerance Heat intolerance

Musculoskeletal: Joint pain Muscle pain Weakness

Neurological: Headaches Fainting Seizures

Psychiatric: Depression Anxiety Suicidal thoughts or plans

None of the above