Grace Evins, MD

Date_____

Legal Name _____Age_____

Preferred Name_____ Chosen Pronoun_____

Date of Birth_____ Social Security #_____

Address _____

City_____ State _____ Zip_____

Home Phone_____ Cell Phone_____

Employer_____ Work Phone_____

Emergency Contact _____Phone_____

Preferred Notification Method _____ Email_____

Ethnicity: Hispanic _____Not Hispanic or Latino _____

Race: White ___ Black or African American ____Asian _____ Other_____

Please list individual we are authorized to speak with in case of an emergency

Name _____Phone _____

Insurance Information (Primary)

Insurance Co _____Group _____Policy_____

Policy Holder Name _____Date of Birth _____

Insurance Information (Secondary)

Insurance Co _____Group_____Policy_____

Policy Holder Name _____Date of Birth _____

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

Rev. 8/18/16

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

DO NOT COPY

Brief Patient Health Questionnaire

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have.

Name _____ DOB _____ Sex: ☐ Female ☐ Male

Date: _____

1. Over the last 2 weeks, how often have you been bothered by any of these problems?	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling or staying asleep or sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself – or that you are a failure or that you have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have moving around more than usual	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

2. Questions about anxiety.	NO	YES
a. In the last four weeks, have you had an anxiety attack – suddenly feeling fear or panic?	☐	☐
If you checked "NO", go to question # 3.		
b. Has this ever happened before?	☐	☐
c. Do some of these attacks come suddenly out of the blue – that is, in situations where you don't expect to be nervous or uncomfortable?	☐	☐
d. Do these attacks bother you a lot or are you worried about having another attack?	☐	☐
e. During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, your heart racing or pounding, dizziness or faintness, tingling or numbness, or nausea or upset stomach?	☐	☐

3. **If you checked off any problems on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

FOR OFFICE CODING: Maj Dep Syn if answers to #1a or b and five or more of #1 a – i are at least "More than half the days" (count #1 if present at all). Other Dep Syn if #1 a or b and two three, or four of #1 a – i are at least "More than half the days" (count #1 if present at all.) Pan Syn if all of #2 a – e are "YES."

4. In the last 4 weeks, how much have you been bothered by any of the following problems?	Not bothered	Bothered a little	Bothered a lot
a. Worrying about your health	☐	☐	☐
b. Your weight or how you look	☐	☐	☐
c. Little or no sexual desire or pleasure during sex	☐	☐	☐
d. Difficulties with husband/wife, partner/lover or boyfriend/girlfriend	☐	☐	☐
e. The stress of taking care of children, parents, or other family members	☐	☐	☐
f. Stress at work outside of the home or at school	☐	☐	☐
g. Financial problems or worries	☐	☐	☐
h. Having no one to turn to when you have a problem	☐	☐	☐
i. Something bad that happened recently	☐	☐	☐
j. Thinking or dreaming about something terrible that happened to you in the past – like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual act	☐	☐	☐

5. In the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act?	NO ☐	YES ☐

6. What is the most stressful thing in your life right now? _____

_____

7. Are you taking any medications for anxiety, depression or stress?	NO ☐	YES ☐

8. FOR WOMEN ONLY: Questions about menstruation, pregnancy and childbirth.

a. Which best describes you menstrual periods?

Periods are unchanged ☐	No periods because pregnant or recently gave birth ☐	Periods have become irregular or changed in frequency, duration or amount ☐	No periods for at least a year ☐	Having periods because taking hormone replacement (estrogen) therapy or oral contraceptive ☐

	NO (or does NOT apply)	YES
b. During the week before you period starts, do you have a serious problem with your mood – like depression, anxiety, irritability, anger or mood swings?	☐	☐
c. If YES: Do these problems go away by the end of your periods?	☐	☐
d. Have you given birth within the last 6 months?	☐	☐
e. Have you had a miscarriage in the last 6 months?	☐	☐
f. Are you having difficulty getting pregnant?	☐	☐

Cancer Family History Questionnaire

Personal Information

Patient Name: _____ Date of Birth: _____ Age: _____

Gender (M/F):_____ Today's Date(MM/DD/YY):_____ Health Care Provider:_____

Your Personal & Family History of Cancer is Important to Provide You With the Best Care Possible

Please mark "Yes" or "No" below if there is a personal or family history of any of the following cancers.
If yes, indicate family relationship and age at diagnosis in the appropriate column.
Include both sides of your family and list each member separately: parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, nephews, and half-siblings.

Personal and Family History Have you or your family members been diagnosed with any of the following:		YOU	SIBLINGS / CHILDREN	MOTHER'S SIDE	FATHER'S SIDE
		Age	Family Member and Age	Family Member and Age	Family Member and Age
EXAMPLE: Breast cancer	☒ Y ○ N	Age 49	Sister 55, Daughter 33	Aunt #1 67 Aunt #2 45	Grandma 84
Breast cancer at or before age 45	○ Y ○ N				
2 or more separate **breast cancers** in one person, one at age 50 or younger	○ Y ○ N				
2 or more people in my family (can include me) with **breast cancer**, one at age 50 or younger	○ Y ○ N				
Ovarian (peritoneal/fallopian tube) cancer at any age	○ Y ○ N				
Triple Negative Breast cancer at age 60 or younger (ER-, PR-, HER2- Pathology)	○ Y ○ N				
3 or more of these cancers on same side of the family at any age: **pancreatic, breast,** or **aggressive prostate*** *Gleason Score ≥7	○ Y ○ N				
Male **breast cancer** at any age	○ Y ○ N				
Ashkenazi Jewish ancestry with **breast or pancreatic cancer** at any age	○ Y ○ N				
Pancreatic cancer or aggressive prostate cancer and one relative with **breast cancer at age 50 or younger**	○ Y ○ N				
20 or more **colon/rectal polyps** found in 1 person throughout their lifetime. Specify number_____	○ Y ○ N				
Colon/rectal or **Endometrial (uterine) cancer** before age 50	○ Y ○ N				
Personal history of **Endometrial (uterine) cancer** at any age‡	○ Y ○ N				
TWO individuals in my family (can include me): at least 1 with **colon/rectal *or* endometrial (uterine) cancer** at any age AND ALSO 1 diagnosed before age 50 with a Lynch-associated* cancer	○ Y ○ N				
THREE OR MORE individuals in my family (can include me) with a **Lynch-associated* cancer** at any age, with at least 1 being a colon/rectal or **endometrial (uterine) cancer**	○ Y ○ N				

‡ $PREMM_{[1,2,6]}$ Score ≥ 5%
* Lynch-associated cancers include: colon, endometrial(uterine), stomach, ovarian, pancreatic, brain, small bowel, kidney, urinary tract, biliary tract, sebaceous (skin gland).

Have you or a family member had genetic testing for a **hereditary cancer syndrome**?	○ Y ○ N	If yes, Who?_____ What gene(s)?_____ What was the result? _____

Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature:_____ Date: _____

Health Care Provider's Signature: _____ Date: _____

Office Use Only

Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☒ DECLINED

If YES, which test? ☐ BRCA*nalysis*® with Myriad myRisk® ☐ Multisite 3 BRCA*nalysis* REFLEX to BRCA*nalysis* with Myriad myRisk

☐ COLARIS®PLUS with Myriad myRisk ☐ COLARIS *AP*®PLUS with Myriad myRisk ☐ Single Site Testing ☐ Myriad myRisk Update ☐ Other:_____

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment:_____

Authorization for Release of Information

Name of Patient_____ Date of Birth_____

Dr. Grace Evins is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information Check each person/entity that you approve To receive information	Description of information to be released Check each that can be given to person on the left in the same section
◯ Voice Mail _____	◯ Results of lab test/x-rays or other _____
◯ Spouse (provide name & phone) _____	◯ Financial _____ Medical as follows _____
◯ Parent (provide name & phone) _____	◯ Financial_____ ◯ Medical as follows _____
◯ Other (provide name & phone) _____	◯ Financial_____ ◯ Medical as follows _____

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in case where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)

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Asheville, NC 28804

PHONE 828-575-9562 FAX 828-575-2884

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PLEASE NOTE: There will be a charge for a copy of our records. Our records will not be sent until payment is made. You may or may not receive an invoice for records sent from another office, to us, depending on that offices' policy. *Please check one option, and complete below:*

☐ Send Records From: Grace G. Evins, MD, To: name / address below

or

☐ Request Records From name / address below, To Grace G. Evins, MD

Doctor or Facility Name _____ Phone _____

Address _____ City, State, Zip _____

Patient's Full Name _____ Patient's Date of Birth _____

Street Address _____

City, State, Zip _____ Daytime Phone _____

Date Range Of Records Requested: From_____ To_____

Specific records requested, within the above date range:

☐ Problem List ☐ Medications List ☐ Pap Results ☐ Lab Results
☐ Obstetric History ☐ Progress notes ☐ Radiology Results ☐ All Records

Purpose of disclosure:

____ Insurance ___Workers Comp __ Referral To Specialist
____ Personal ___ Legal Investigation __ Disability Determination
___ Transferring Care To Another Dr ___Other (specify)_____

___I do,___I do NOT authorize release of information related to AIDS infection, psychiatric care, psychological assessment, and treatment for alcohol and/or drug abuse. I authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation.

Signature of individual, or guardian, or personal representative of patient's estate) _____ Date Signed _____

Revised 3/16/15