PATIENT HISTORY SHEET

Note: This is a confidential record that will be shredded upon entry into our electronic health record. Information contained here will not be released to anyone without your authorization to do so.

Last Name: _____ First Name _____ Age: _____

Who referred you to us? _____ Who is your primary care provider? _____

How did you hear about EvergreenHealth (circle one)? My primary care MD Internet Friend/family ER/urgent care Other

To whom would you like us to fax your consultation note? _____

Chief Complaint: What is the main symptom you would like for us to address today? While we will discuss your entire history, knowing the single most important thing to you will help to get started.

_____

Have you seen an urologist, gynecologist, urogynecologist or FPMRS specialist before (circle one)? Y N Unsure

If yes, list their names here: _____

Have you had an ultrasound, X-ray, MRI, or CT (CAT) scan of your abdomen or pelvis (circle one)? Y N

If yes, please list what type (ie, CT, MRI), and where done (Swedish, Virginia Mason, Overlake, etc.):

_____

Please list all of your current and past medical diagnoses:

1) _____ 2) _____

3) _____ 4) _____

5) _____ 6) _____

Please list your past Surgeries:

Type of surgery ***Date of Surgery***

1) _____

2) _____

3) _____

4) _____

SOCIAL HISTORY:

Tobacco History (circle one)? Current Smoker Former Smoker (Quit Date: _____) Never Smoked

Years smoked : _____ Number of cigarettes per day (circle one): < 1/2 pack 1/2 pack 1 pack > 1 pack

Relationship status (circle one): Single Married Significant other

APPLY PATIENT LABEL HERE

How much do you drink per day of the following (best estimate):

Coffee / Tea / Caffeine: _____

Carbonation (soda, sparkling water): _____

Water: _____

Alcohol: _____

ALLERGIES:

Medication ***Reaction (hives, can't breathe, etc.)***

1) _____

2) _____

3) _____

4) _____

MEDICATION LIST: FOR YOUR SAFETY, PLEASE LIST ALL MEDICATIONS THAT YOU TAKE ALONG WITH DOSES. Include supplements, topical creams such as steroids or vaginal estrogen, over the counter and prescription medications. If you have some medications that you only take "as needed" please include those too. Because medications we may prescribe can have unsafe interactions with other medications, please provide an accurate list along with dosages below.

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

8) _____

9) _____

FAMILY HISTORY: Does anyone in your immediate family (parents, siblings, children) have a history of heart disease, heart attack, diabetes, ovarian cancer, breast cancer, kidney cancer, bladder cancer, colon cancer, or any other serious illnesses?

_____

_____

_____

_____

APPLY PATIENT LABEL HERE

OBSTETRICAL HISTORY:

Number of Pregnancies: _____ Number of Vaginal Deliveries: _____ Number of Cesarean Deliveries: _____

Weight of heaviest baby: _____ lb _____ oz Were any deliveries assisted with forceps or vacuum? Y N

Any complications with any of your deliveries? _____

GYNECOLOGIC HISTORY:

Date of Last PAP Smear: _____ History of abnormal PAP Smears?_____

Date of Last Mammogram: _____ History of abnormal mammogram?_____

Date of Last Colonoscopy: _____ History of abnormal colonoscopy_____

Date of Last Menstrual Cycle:_____ History of hormone use currently or in the past? Y N

Current Form of Birth Control (circle one or more): Menopause Abstinence Condoms Pills IUD

Vasectomy Tubal Ligation Other: _____

Please write any further comments or things you would like us to know in the space below.

_____

_____

_____

_____

_____

_____

_____

_____

APPLY PATIENT LABEL HERE

Medication History Authorization

Effective July 10, 2012

Date: _____

I hereby give authorization to the physicians of EvergreenHealth to review my medication history as prescribed by other physicians.

_____ _____

Printed Name Signature

APPLY PATIENT LABEL HERE

EvergreenHeallh Review of Symptoms:

Please circle all that apply. These are symptoms that you are having now that you would like us to know about.

Constitutional symptoms

Fever

Chills

Weight change

Respiratory

Chronic cough

Wheezing

Gastrointestinal

Abdominal pain

Blood in stool

Constipation

Diarrhea

Nausea

Vomiting

Neurological

Difficulty walking

Headache

Memory loss

Seizures

Tremors

Musculoskeletal

Arthritis

Back pain / neck pain

Joint pain

Head. neck, ears, nose and throat

Blurred vision

Double vision

Hearing loss

Sinus infection

Sore throat

Cardiovascular

Chest pain

Murmur

Palpitations

Genitourinary

Dysuria

Hematuria

Psychiatric

Anxiety

Depression

Insomnia

Hematologic / lymphatic

Easy bleeding

Abnormal clotting

APPLY PATIENT LABEL HERE