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PATIENT'S MEDICAL HISTORY

First Name: _____ **MI:** _____ **Last Name:** _____

Please circle all that apply:

Alcohol or drug abuse Allergies Anxiety Arthritis Asthma
Autoimmune Disease Back Pain Birth Defects Blood Disease Bone and Joint Disease
Cancer Colitis/Crohn's Disease Depression Hearing Disorder Diabetes Epilepsy
Gastrointestinal Disease/Heartburn/Ulcers Glandular Disorder Heart Disease
High Blood Pressure High Cholesterol IBS Infertility or Repeat Pregnancy Loss
Intellectual Disabilities Immunodeficiency Disorder Insulin Resistance Kidney Disease
Lung Disease: Emphasema, Lung Cancer, COPD Memory Problems Migraines
Muscular Disease Nerve Disorder Ocular Disease Skin Disease Sleep Apnea Stroke
Thyroid Disease

SPECIALISTS

Please list the names and phone numbers of specialists that you see:

Name _____ Phone Number _____

Name _____ Phone Number _____

Name _____ Phone Number _____

Name _____ Phone Number _____

Name _____ Phone Number _____