Main Line HealthCare
Physician Network

PATIENT NAME:_____ **DATE:**_____

PAST MEDICAL HISTORY

Age:_____ Height:_____ Weight:_____ Reason for Visit?_____

MEDICATIONS: Name	Dose	Frequency

Have you had any of the following?
Please check appropriate boxes.

Past Medical History

- ☐ High Blood Pressure
- ☐ Acute Myocardial Infarction
- ☐ A-Fib
- ☐ Coronary Artery Disease
- ☐ Stroke
- ☐ Venous Thrombosis (DVT)
- ☐ Cancer Type:_____
- ☐ High Cholesterol
- ☐ Diabetes Mellitus
- ☐ Thyroid Disorder Type:_____
- ☐ Esophageal Reflux
- ☐ Seizure Disorder
- ☐ Asthma
- ☐ COPD
- ☐ Sleep Apnea
- ☐ Osteoporosis
- ☐ Renal Failure
- ☐ Blood Disorder Type:_____
- ☐ HIV Infection
- ☐ Hepatitis
- ☐ Other_____

Referring Provider:

_____

Address: _____

_____

Phone: ( )_____

Family Doctor:_____
Phone: ( )_____

Cardiologist:_____
Phone: ( )_____

Other:_____
Phone: ( )_____

Do you have a **pacemaker**? Yes No

Are you presently on **dialysis**? Yes No

Do you have a **cardiac stent**? Yes No

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Allergies/Reaction

Please list any allergies including those to drugs, latex, adhesive tape, food, etc. and include your reaction:

_____

_____

_____

_____

SURGICAL HISTORY: **Date** **Name of Surgery**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

HOSPITALIZATIONS: **Date** **Reason (no surgeries, please)**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

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Name:_____ DOB:_____ Date:_____

FAMILY HISTORY:

	Alive	Deceased	Unknown	Present Illness / Cause of Death (please include age at diagnosis of breast and colon cancers, if possible)
Father	☐	☐	☐	_____
Mother	☐	☐	☐	_____
Paternal Grandfather	☐	☐	☐	_____
Paternal Grandmother	☐	☐	☐	_____
Maternal Grandfather	☐	☐	☐	_____
Maternal Grandmother	☐	☐	☐	_____
Brothers	☐	☐	☐	_____
Sisters	☐	☐	☐	_____
Children	☐	☐	☐	_____

Social History

Current Smoker: ☐Y ☐N

Packs per day?_____ No. of years?_____

Former Smoker: ☐Y ☐N

Year you quit:_____

Other Tobacco Use? ☐Y ☐N

Type?_____

Alcohol Use: ☐Y ☐N

Frequency?_____

Recreational Drug Use: ☐Y ☐N

Type/frequency?_____

Women Only:

Age at first period:_____

Number of pregnancies:_____

Number of children:_____

Date of last period:_____

Age at first birth:_____

Age at menopause:_____

Number of previous breast biopsies:_____

Family history of breast/ovarian cancer: Yes No

History of hormone replacement use: Yes No

Length of time taken:_____ Therapy: Yes No

History of birth control use: Yes No

Length of time taken: _____

Name:_____ Date of Birth:_____

Do you currently have any of the following?

General Symptoms

☐Y ☐N Weight Change
If yes, indicate gained or lost?_____
Amount?_____
☐Y ☐N Increase in Appetite
☐Y ☐N Decrease in Appetite
☐Y ☐N Fever
☐Y ☐N Chills
☐Y ☐N Tiring Easily

Skin Symptoms

☐Y ☐N Itching
☐Y ☐N Skin Lesions
☐Y ☐N Rashes
☐Y Other:_____

Head Symptoms

☐Y ☐N Headache
☐Y ☐N Corrective Lenses
☐Y Other:_____

Neck Symptoms

☐Y ☐N Neck Pain
☐Y ☐N Neck Stiffness
☐Y ☐N Lump or Swelling
☐Y Other:_____

Otolaryngeal Symptoms

☐Y ☐N Earache
☐Y ☐N Hearing Loss
☐Y ☐N Nosebleeds
☐Y ☐N Mouth Sores
☐Y ☐N Bleeding Gums
☐Y ☐N Hoarseness
☐Y ☐N Throat Pain
☐Y Other:_____

Cardiovascular

☐Y ☐N Chest Pain or Discomfort
☐Y ☐N Fast Heart Rate
☐Y ☐N Palpitations
☐Y Other:_____

Pulmonary Symptoms

☐Y ☐N Wheezing (Asthma)
☐Y Other:_____

Endocrine Symptoms

☐Y ☐N Excessive Sweating
☐Y ☐N Excessive Thirst
☐Y Other:_____

Hematologic Symptoms

☐Y ☐N Easy Bleeding
☐Y ☐N Easy Bruising Tendency
☐Y Other:_____

Gastrointestinal Symptoms

☐Y ☐N Difficulty Swallowing
☐Y ☐N Heartburn
☐Y ☐N Ulcer
☐Y ☐N Nausea
☐Y ☐N Vomiting
☐Y ☐N Abdominal Pain
☐Y ☐N Bowel/Bladder Changes
☐Y ☐N Diarrhea
☐Y ☐N Constipation
☐Y ☐N Black or Tarry Stools
☐Y ☐N Rectal Bleeding
☐Y Other:_____

Genitourinary Symptoms

☐Y ☐N Pain During Urination
☐Y ☐N Increased Urinary Frequency
☐Y ☐N Blood in Urine
☐Y ☐N Genital Lesion
☐Y Other:_____

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Do you currently have any of the following?

Musculoskeletal Symptoms

☐Y ☐N Joint Pain
☐Y ☐N Joint Stiffness
☐Y ☐N Muscle Aches
☐Y Other:_____

Psychological Symptoms

☐Y ☐N Sleep Disturbances
☐Y ☐N Anxiety
☐Y ☐N Depression
☐Y Other:_____

Neurological Symptoms

☐Y ☐N Dizziness
☐Y ☐N Veritgo
☐Y ☐N Fainting
☐Y ☐N Motor Disturbances
☐Y ☐N Sensory Disturbances
☐Y Other:_____

Screening and Immunization History

(All patients)

Did you receive a flu vaccination during last year's flu season (October - March)? ☐Y ☐N

Approximate Date_____

*Surgical Specialists' physicians recommend you obtain an annual flu vaccine.

(All patients ages 50-75)

When was your last colonoscopy?_____

*Surgical Specialists' physicians recommend you have a screening colonoscopy every 10 years unless otherwise indicated by your family doctor or specialist.

(Female patients age 40 or older)

When was you last mammogram?_____

*Surgical Specialists' physicians recommend you have a yearly screening mammogram.

(All patients age 65 or older)

Have you ever received a pneumonia vaccination?

☐Y ☐N Approximate Date_____

*Surgical Specialists' physicians recommend you receive a pneumonia vaccine if you are age 65 or older and have not yet received one.

I VERIFY THAT THE INFORMATION ON THIS QUESTIONNAIRE IS CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE _____ DATE _____