Main Line HealthCare
Physician Network

PAST MEDICAL HISTORY

Patient Name:_____ DOB:_____

To assist Dr. Margolies and Dr. Park in serving your needs, please take time to provide some preliminary information.

Please list current medications including vitamins and over the counter drugs.

Medication	Dose	Frequency	Medication	Dose	Frequency

Please list any medication that have caused an allergic reaction

Medication	Allergic Response

List Major Surgeries/Hospitalizations/Trauma

Reason for Surgery/Hospitalization	Year

What is your highest level of education: High School College Graduate School

Smoking History: Never Current Smoker How Many Packs/Day_____ How Long_____ Quit Smoking When_____

Do you drink alcohol: Never Socially 1/Day 2/Day More than 2/Day

Recreational Drug Use: Never Sometimes Daily

If yes, what drug(s)_____

Are you in recovery for prior drug/alcohol use: Yes No

Marital Status: Married Single Divorced Widow Significant Other

Work Status: Employed Unemployed Retired

Current or previous job_____

Have you recently experienced any of the following symptoms:

Fever	yes	no	Loss of vision	yes	no
Weight loss	yes	no	Double Vision	yes	no
Rashes	yes	no	Hearing loss	yes	no
Joint Pain	yes	no	Ringing in Ears	yes	no
Muscle Pain	yes	no	Dizziness	yes	no
Easy Bruising	yes	no	Trouble Swallowing	yes	no
Miscarriages	yes	no	Trouble Talking	yes	no
Neck Pain	yes	no	Weakness	yes	no
Back Pain	yes	no	Numbness	yes	no
Trouble Breathing	yes	no	Tingling	yes	no
Chest Pain	yes	no	Trouble Walking	yes	no
Palpitations	yes	no	Head Trauma	yes	no
Nausea/Vomiting	yes	no	Headaches	yes	no
Diarrhea	yes	no	Seizures	yes	no
Discolored Urine	yes	no	Memory Loss	yes	no
Incontinence	yes	no	Confusion	yes	no
Impotence	yes	no	Trouble Sleeping	yes	no
Skin Changes	yes	no	Anxiety	yes	no
Hair Changes	yes	no	Depression	yes	no

Do you have or have you ever had:

High Blood Pressure	yes	no	Stroke	yes	no
Diabetes	yes	no	Cancer	yes	no
Heart Attack	yes	no	Psychiatric disorder	yes	no
High Cholesterol	yes	no	Vascular disease	yes	no
Epilepsy	yes	no	Migraine	yes	no

Family History-Parents, siblings, children with chronic medical problems:

Relative	Age	Medical Problem	Age Death	Cause of Death
Mother				
Father				
Sibling				
Sibling				
Child				
Child				
Other				
Other				

History Reviewed and Updated

Physician Date and Signature