Main Line HealthCare
Physician Network

Today's Date:

NEW PATIENT ADULT COMPREHENSIVE HEALTH ASSESSMENT

Please answer these questions to help us maintain accurate records and provide high quality care. All information will be kept confidential. Please discuss any questions about these items with your doctor or clinical staff.

Patient Name: DOB:

Do you have a living will, advance directive or DNR? □ Yes □ No
Do you have any special hearing needs? □ Yes □ No Do you have vision impairment? □ Yes □ No

Preferred Pharmacy

Name: Location: Number:

Medications

Please list all your MEDICATIONS (prescriptions, over the counter, vitamins, herbal supplements). Include the dose and frequency for each.

Drug Name	Dosage	Drug Name	Dosage

Allergies

Do you have any allergies to medications, foods, or other substances? If yes, please list each and the reaction you've experienced.

Allergic to	Reaction	Allergic to	Reaction

Chronic Conditions / Past Medical History

□ High Blood Pressure	□ Pneumonia	□ Urinary Tract Infection / UTI	□ Hemorrhoids
□ High Cholesterol	□ COPD/Emphysema/Bronchitis	□ Kidney Disease	□ Gastrointestinal Ulcers
□ Diabetes	□ Asthma	□ Kidney Stones	□ Diverticulitis or Diverticulosis
□ Heart Attack / MI	□ Turberculosis / TB	□ Thyroid Disease	□ Heartburn / Reflux Problems
□ Heart Failure / CHF	□ Sexually Transmitted Infection	□ Allergies / Hay Fever	□ Arthritis / Joint Problems
□ Depression	□ Other Sexual Problems	□ Blood or Bleeding Disorders	□ Skin Disease
□ Anxiety	□ Abnormal Pap Smear	□ Anemia	□ Drug Problems
□ Cancer **(Please list type below)**	□ Prostate Problems	□ Hepatic / Liver Disease	□ Alcohol Problems
			□ **Other (Please explain below)**

Cancer:
Other:

Surgical History

Please list all OPERATIONS you have had and give the approximate DATE of each:

Operation	Date	Operation	Date
□ Appendectomy		□ Joint surgery	
□ Cholecystectomy (gallbladder out)			
□ Hysterectomy			
□ Heart surgery			

Hospitalizations

Please list the diagnosis/reason for all HOSPITALIZATIONS you have had and give the approximate DATE of each:

Diagnosis/Reason	Date	Diagnosis/Reason	Date

PLEASE TURN OVER AND COMPLETE SIDE 2

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Patient Name: DOB:

Diagnostic Studies (for example: stress tests, echocardiograms, CAT scans, MRIs)

Please list all DIAGNOSTIC STUDIES you have had and give the approximate DATE of each:

Study	Date	Study	Date
□ Heart Stress Test			
□ Echocardiogram			
□ Heart Catheterization			

Family History

Has anyone in your IMMEDIATE family had any of the following illnesses?

Illness	Family Member / Age Diagnosed	Illness	Family Member / Age Diagnosed
Cancer (list type)		Suicide / Suicide Attempt	
High Blood Pressure		Asthma	
High Cholesterol		Osteoporosis / Thinning Bones	
Diabetes		Glaucoma	
Heart Attack / MI		Kidney Disease	
Stroke or Mini-Stroke / TIA		Bleeding Disorder	
Depression / Bipolar		Genetic Disorder	
Drug/Alcohol Problems		Other (list type)	

Is your mother alive? □ Yes □ No If not, age at death and cause of death: _____

Is your father alive? □ Yes □ No If not, age at death and cause of death: _____

Social / Occupational History

Present Occupation? _____

Previous Occupation? _____

Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? If so, which ones?

_____

Have you ever been exposed to any environmental hazards such as radiation, toxic waste, or lead paint? If so, which ones?

_____

Lifestyle / Safety

Do you use tobacco products? □ Yes □ No If yes, what kind? _____ How much? _____

Do you drink alcohol? □ Yes □ No If yes, what kind? _____ How much per week? _____

Do you drink caffeine? □ Yes □ No If yes, what type / how much? □coffee_____ □tea_____ □soda_____

Do you exercise? □ Yes □ No If yes, what type / how much? □cardio □weights □swim

_____

Do you follow a particular diet? □ Yes □ No □low fat □low salt □low carbohydrate □vegetarian □vegan □gluten-free

Do you have smoke detectors? □ Yes □ No

Do you have a gun in your house? □ Yes □ No If yes, is it under lock and key? _____

Do you wear a seatbelt? □ Yes □ No

Have you travelled outside the U.S.? □ Yes □ No If yes, where? _____

Answering the following questions will help us provide the best possible care. Your answers will be confidential.

Do you use drugs? (Cocaine, marijuana, opiates, etc.) □ Yes □ No If yes, what type? _____

Have you been sexually active? □ Yes □ No If yes, with □men □women □both

How many sexual partners have you had? currently_____ lifetime_____

Do you practice safe sex? □ Yes □ No If yes, what method of protection do you use? _____

Do you use condoms? □Yes □ No If yes, how often do you use them? □ Always □ Sometimes

Do you use other contraception? □ Yes □ No If yes, what? □birth control pills □IUD □sponge □diaphragm □rhythm method

PLEASE COMPLETE SIDE 3

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NEW PATIENT ADULT COMPREHENSIVE HEALTH ASSESSMENT

Patient Name: DOB:

Health Maintenance

When was your LAST (Please give approximate date):

Pap Smear		Prostate Exam / PSA	
Breast Exam		Stool Check for Blood	
Mammogram		Colonoscopy Exam	
DEXA Scan		Cholesterol Check	
		Complete Physical	

Immunizations

Have you had any of these IMMUNIZATIONS?

Influenza/Flu	□ No □ Yes, Date:	Hepatitis B	□ No □ Yes, Date:
Tetanus/Td alone	□ No □ Yes, Date:	HPV/Cervical Cancer	□ No □ Yes, Date:
Tetanus with Pertussis/Tdap	□ No □ Yes, Date:	Zoster/Shingles	□ No □ Yes, Date:
Pneumonia/Pneumovax	□ No □ Yes, Date:	Meningococcal	□ No □ Yes, Date:

Patient Health Questionnaire (PHQ-2): Please circle your response.

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3