Main Line HealthCare
Physician Network

PAST MEDICAL HISTORY FORM

PATIENT NAME:_____ **DATE:**_____

Check if you are currently being treated or have been treated for any of the following illnesses:

- ❑ Heart problems
- ❑ High blood pressure
- ❑ Diabetes
- ❑ Cancer
- ❑ Asthma
- ❑ Other_____

WomenOnly:
Age at first period: _____
Number of pregnancies:_____
Number of children: _____

Age at first birth: _____
Age at menopause: _____
Number of previous breast biopsies:_____
Family history of breast/ovarian cancer:____
History of Tamoxifen or Evista use:_____

Are you allergic to any **medications**? Yes No
If yes, please specify medication and describe reaction:

Do you have a **pacemaker**? Yes No Are you presently on **dialysis**? Yes No

Have you had any **operations**? Please list type of surgery and approximate date:
_____
_____

PLEASE LIST MEDICATIONS THAT YOU ARE TAKING. WE CAN COPY A LIST.
IF YOU ARE NOT TAKING ANY PLEASE LIST NONE TAKEN.

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Social History
Marital Status: S M W D

Health Habits:
Did you smoke? Yes No How many packs per day? When did you quit?
Do you smoke currently? Yes No How many packs per day? How many years?
Do you drink alcohol? Yes No How much? _____
Do you use any recreational drugs? Yes No

Family History
Check if any close family members (parents, siblings, children) have/had:
Heart problems High blood pressure Diabetes Cancer
Other _____

REVISED 12/17/14