Main Line HealthCare
Physician Network

MLHC Surgical Associates

Patient Health Questionnaire

Name:_____ DOB:_____ Date:_____

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

Referring Provider:

_____

Address: _____

_____

Phone: ( )_____

Family Doctor:_____

Phone: ( )_____

Cardiologist:_____

Phone: ( )_____

Other:_____

Phone: ( )_____

Medications

Please list your medications with dosages (include all prescription, non-prescription and herbal treatments).

_____

_____

_____

_____

_____

_____

_____

_____

Allergies/Reaction

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

_____

_____

_____

_____

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_____

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?_____

Name: _____ Date: _____

Family History

Cancer: ☐ Y ☐ N Type:_____
Relationship:_____

Heart Disease: ☐ Y ☐ N Relationship:_____

High Blood Pressure: ☐ Y ☐ N Relationship:_____

Diabetes Mellitus: ☐ Y ☐ N Relationship:_____

Other: ☐ Y _____

Past Surgical History

Please list the date and type of any previous surgery:

_____
_____
_____
_____
_____
_____
_____
_____

Have you ever had a problem with anesthesia? (please explain)

_____
_____
_____

Have any of your family members ever had a problem with anesthesia? (please explain)

_____
_____
_____

Do you currently have any of the following?

Allergies:
☐ Y ☐ N

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:_____

Eye Symptoms

☐ Y ☐ N Vision Problems
☐ 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:_____

Name:_____ Date:_____

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:_____

Musculoskeletal Symptoms

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

Neurological Symptoms

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

Psychological Symptoms

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

Female Patients Only:

Date of Last Menstrual Period_____

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.