Claudia L. Hargrove, M.D.
Priscilla P. Chiu, M.D.
Rajnee Dhawan, M.D.
Brandon Twombly, M.D.

Main Line Family Practice
New Patient Forms

955 Haverford Road Suite 300 | Bryn Mawr, PA 19010
Phone | 610-525-2990 Fax | 610-525-2099

RM:_____ MA:_____
Date:_____

Name:_____ DOB____/____/_____

Gender Identity: ☐ Male | ☐ Female | ☐ Trans Male | ☐ Trans Female | ☐ Non-binary | ☐ Other:_____
Sex at birth: ☐ Male | ☐ Female

Pharmacy:_____ St:_____ Area:_____

Office use: **BP**____/____ R/L arm **T**_____ **RR**_____ **PR**_____ **02%**_____ **Wt**_____ **Ht**_____

Today's visit: Concerns/ problems:_____

Last Menstrual Period___/___/___

Hospital visits (last 30 days)
☐ No ☐ Yes:_____

Falls (In the last year)
☐ No ☐ Yes:_____

Medications/ Supplements: Name, dosage and, # times/day

1_____
2_____
3_____
4_____
5_____
6_____
7_____
8_____
9_____
10_____
11_____

Allergies and reaction: ☐ No Known Drug Allergies
Yes, if so list below
_____
_____

Vision: Do you….
Poor eyesight ☐ No ☐ Yes
Wear Glasses ☐ No ☐ Yes
Wear Contacts ☐ No ☐ Yes

Current Medical Conditions (ex. High blood pressure)

_____
_____
_____
_____
_____

Past Medical Conditions (ex. heart attack)

_____
_____
_____
_____
_____

Cancer ☐ No ☐ Yes, please list:_____
Behavioral Health (anxiety, depression, ADHD, etc.) ☐ No ☐ Yes, please list:_____

Surgical/ Procedural History and Hospitalizations: (ex. Cataracts, tooth extraction, reduction of fractures)

_____
_____
_____
_____

Specialists: List first, last name, and specialty below (ex. Ob/Gyn, Cardiologist, ENT, Dermatologist)

_____
_____
_____
_____

_____
_____
_____
_____

Main Line Family Practice
New Patient Forms Date:_____

955 Haverford Road Suite 300 Bryn Mawr, PA 19010
Phone| 610-525-2990 Fax| 610-525-2099

Name:_____ DOB____/____/____

Gynecological History:

Have you ever had an **abnormal Pap smear?** ☐ No ☐ Yes, approx. date/s:_____
Menstrual cycle: Age at first menstruation:_____
How many days apart? (first to first):_____ How many days long?:_____
Do you have any heavy clotting/ heavy bleeding? (please explain):_____
Menopause?: ☐ No ☐ Yes, age at last menstruation:_____
Pregnancies?: ☐ Never ☐ Yes, number:_____ Total births:_____ Full term:_____ Preterm:_____
Vaginal birth/s?:_____ **Cesarean section/s**?:_____
Miscarriage/s? ☐ No ☐ Yes, number:_____ **Abortion/s?** ☐ No ☐ Yes, number:_____
Birth Control Pill? ☐ No ☐ Yes, years of usage:_____ **IUD?** ☐ No ☐ Yes, years of usage:_____
Depo-Provera/ Nexplanon/ Nuva-ring/ Ortha-Evra patch? ☐ No ☐ Yes (**circle** which applies) Years of usage:____
Other hormone therapy? ☐ No ☐ Yes, explain:_____
History of HPV/ HSV (Herpes)/ Gonorrhea/ Chlamydia/ Syphilis? ☐ No ☐ Yes (**circle** which applies)
Colposcopy? ☐ No ☐ Yes **D&C/ D&E?** ☐No ☐ Yes (**circle** which applies)
Uterine abnormalities? (ex. Fibroids, endometriosis, etc) ☐ No ☐ Yes, explain:_____
Uterine ablation? ☐ No ☐ Yes **Other female specific surgeries?** ☐ No ☐ Yes, list:_____

Social History:

Tobacco use: ☐ Never ☐ Former Quit year:_____ # of years used:_____ # of packs daily/weekly:_____
☐ Yes, form of use (ex. cigars, vape, chew):_____ # of years used:_____ # of packs daily/weekly:_____
Secondhand-smoke exposure at home? ☐ No ☐ Yes
Alcohol use: ☐ No ☐ Yes, type:_____ # of drinks daily/weekly_____
Alcohol-dependency? ☐ No ☐ Yes, # of years:_____ ☐ Former, yes # of years:_____
Recreational drug use: ☐ No ☐ Yes, # of years_____ Drug/s:_____ Frequency:_____
Diet (describe):_____
Exercise: ☐ No ☐ Yes, # of days weekly:_____ Type/s of exercise:_____
Caffeinated drinks: coffee/ tea/ soda/ energy ☐ No ☐ Yes (**circle** which applies) # of cups daily:_____
Education (highest level):_____ ☐ Currently enrolled student
Military service: ☐ No ☐ Yes, active duty ☐ Yes, retired
Occupation:_____ full-time/ part-time/ retired/ homemaker (**circle** which applies)
Stress level: ☐ Low ☐ Medium ☐ High Cause:_____
Marital status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed
Children: ☐ No ☐ Yes # of daughters_____ # of sons_____
Who lives with you?:_____ ☐ live alone **Pets:** ☐ No ☐ Yes, list:_____
Is faith (religion) important to you? ☐ No ☐ Yes, religion:_____
Sexually activity: ☐ No ☐ Yes (**circle** which applies) Men/ Women/ Both Condom use: ☐ No ☐ Yes

Health Maintenance: Please fill in date of last exam

Colonoscopy___/___/___	**Mammogram**___/___/___	**GYN/ PAP**___/___/___	**DEXA**___/___/___
☐ Colectomy P/ T	☐ Mastectomy L/ R/ B	☐ Hysterectomy P/ T	☐ Osteoporosis/penia
☐ Never ☐ Cologuard	☐ Never	☐ W/breast	☐ Never
Prostate___/___/___	**Hearing**___/___/___	**Eye**___/___/___	**Dental**___/___/___
☐ Prostatectomy	☐ Hearing loss	☐ Diabetic exam	
☐ Never	**Foot**___/___/___	**Lab work**___/___/___	**Skin**___/___/___

Main Line Family Practice
New Patient Forms Date:_____

955 Haverford Road Suite 300 Bryn Mawr, PA 19010
Phone| 610-525-2990 Fax| 610-525-2099

Name:_____ DOB____/____/____

Family History:

Number of sisters:_____ Number of brothers:_____

Check box if family member has the particular health condition and list their age when diagnosed
If you have more than one sibling listed age next to health condition checked off

	Father	Mother	Sister/s	Brother/s	Maternal Grand mother	Maternal Grand father	Paternal Grand mother	Paternal Grand father
Alive/ Deceased Age/s								
High blood pressure								
Arrhythmia								
Heart attack (MI)								
Heart disease								
Heart valve disorder								
Stroke (CVA)								
High cholesterol								
Diabetes (type)								
Thyroid disorder								
Osteoporosis/ penia								
Asthma								
Reflux								
Liver disease								
Kidney disease								
Migraines								
Seizures								
Parkinson's								
Alzheimer's								
Gout								
Glaucoma								
Anxiety								
Depression								
Cancer (type)								

Additional health problems (relative and problem):_____
_____
_____

Immunizations

Tetanus____/____/____ **Gardasil (HPV)**____/____/____ **Pneumovax 23**____/____/____ **Shingrix (1)**____/____/____
Flu____/____/____ **Prevnar 13**____/____/____ **Meningitis**____/____/____ **Shingrix (2)**____/____/____
Hepatitis A___/___/___ **Hepatitis B**___/___/___
COVID-19 Brand:_____ Dose 1:____/____/____ Dose 2:____/____/____ Booster:____/____/_____

All the information listed is true to the extent of my knowledge

_____ _____
Patient signature **Date** **Physician signature** **Date**

Main Line Family Practice
New Patient Forms Date:_____

955 Haverford Road Suite 300 Bryn Mawr, PA 19010
Phone| 610-525-2990 Fax| 610-525-2099

Name:_____ DOB____/____/____

Review of Systems: Check box if you have any of the following

General
- Unexpected weight gain/ loss ☐ Y
- Loss of appetite ☐ Y
- Night sweats ☐ Y
- Fatigue ☐ Y
- Fever/ Chills ☐ Y
- Insomnia ☐ Y

Head and Neck
- Headaches ☐ Y
- Double vision ☐ Y
- Changes in vision ☐ Y
- Ringing in ear ☐ Y
- Hoarseness ☐ Y
- Sinus problems ☐ Y
- Nose bleeds ☐ Y
- Sores (mouth/lip/tongue) ☐ Y

Respiratory
- Cough (acute or chronic) ☐ Y
- Difficulty breathing/ SOB ☐ Y
- Pneumonia ☐ Y
- Bronchitis ☐ Y
- Wheezing ☐ Y
- Snoring ☐ Y

Heart and Circulatory
- Chest pain/ pressure ☐ Y
- Palpitations ☐ Y
- Fainting/ lightheadedness ☐ Y
- Leg cramps ☐ Y
- Ankle swelling ☐ Y

Psych
- Anxiety ☐ Y
- Depression ☐ Y
- Mood changes ☐ Y

Urinary
- Night-time urination ☐ Y
- Urinary tract infection ☐ Y
- Urinary frequency ☐ Y
- Urinary urgency ☐ Y
- Difficulty voiding ☐ Y
- Blood in urine ☐ Y
- STI/ STD ☐ Y
- Urine leakage ☐ Y
- Painful urination ☐ Y

Neuro
- Seizures ☐ Y
- Tremors ☐ Y
- Difficulty speaking ☐ Y
- Unsteadiness/falls ☐ Y
- Memory loss ☐ Y
- Numbness ☐ Y
- Tingling ☐ Y
- Vertigo/ dizziness

Gastro
- Heartburn ☐ Y
- Difficulty swallowing ☐ Y
- Nausea/ vomiting ☐ Y
- Constipation ☐ Y
- Diarrhea ☐ Y
- Blood in stool ☐ Y
- Black/ tarry stool ☐ Y
- Hepatitis ☐ Y
- Abdominal pain ☐ Y

Skin
- Changes in hair/skin ☐ Y
- New/ change mole/s ☐ Y
- Rash ☐ Y
- Where?_____

Bone and Joint
- Joint pain ☐ Y
- Joint stiffness ☐ Y
- Joint swelling ☐ Y
- Location:_____
- _____

Blood
- Bruising ☐ Y
- Anemia ☐ Y
- Swollen glands ☐ Y
- Blood donations ☐ Y
- Blood transfusion ☐ Y

Women Only
- Irregular periods ☐ Y
- Breast lump/s ☐ Y
- Nipple discharge ☐ Y
- Breast pain ☐ Y
- Menopause ☐ Y
- Abnormal pap ☐ Y
- Vaginal bleeding ☐ Y
- Vaginal discharge ☐ Y
- Change in sex drive ☐ Y
- Painful intercourse ☐ Y
- Hot flashes ☐ Y

Men Only
- Difficulty w/erection ☐ Y
- Painful ejaculation ☐ Y
- Bloody ejaculation ☐ Y
- Retrograde ejaculation ☐ Y
- Change in sex drive ☐ Y

Endocrine
- Increased thirst ☐ Y
- Increased urination ☐ Y
- Increased hungry ☐ Y

Have you had less interest or pleasure in doing things you normally enjoy? ☐ No ☐ Yes

Have you been feeling down, depressed, or hopeless? ☐ No ☐ Yes

Main Line Family Practice
New Patient Forms
955 Haverford Road Suite 300 Bryn Mawr, PA 19010
Phone| 610-525-2990 Fax| 610-525-2099

Date:_____

Name:_____ DOB____/____/____

Alcohol Use (Audit C)

Did you have a drink containing alcohol in the past year?

☐ No

☐ Yes

If "Yes": How often did you have a drink containing alcohol in the past year?

☐ Never (0 points)

☐ Monthly or less (1 point)

☐ 2 to 4 times a month (2 points)

☐ 2 to 3 times a week (3 points)

☐ 4 or more times a week (4 points)

If "Yes": How many drinks did you have on a typical day when you were drinking in the past year?

☐ 1 or 2 drinks (0 points)

☐ 3 or 4 drinks (1 point)

☐ 5 or 6 drinks (2 points)

☐ 7 to 9 drinks (3 points)

☐ 10 or more drinks (4 points)

If "Yes": How often did you have 6 or more drinks on one occasion in the past year?

☐ Never (0 points)

☐ Less than monthly (1 point)

☐ Monthly (2 points)

☐ Weekly (3 points)

☐ Daily or almost daily (4 points)

Interpretation

☐ Positive

☐ Negative

Points:_____

Interpretation Scale

The AUDIT-C is scored on a scale of 0-12 (Scores of 0 reflect no alcohol use)

* In men, a score of 4 or more is considered positive
* In women, a score of 3 or more is considered positive

Main Line Family Practice
New Patient Forms
955 Haverford Road Suite 300 Bryn Mawr, PA 19010
Phone| 610-525-2990 Fax| 610-525-2099

Date:_____

Name:_____ DOB____/____/____

Patient Health Questionnaire (PHQ-9)
Depression Screening

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "x" to indicate your answer)

	Not at all 0	Several days 1	More than half the days 2	Nearly everyday 3
1) Little interest or pleasure in doing things you normally enjoy	☐	☐	☐	☐
2) Feeling down, depressed or hopeless	☐	☐	☐	☐
3) Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4) Feeling tired or having little energy	☐	☐	☐	☐
5) Poor appetite or overeating	☐	☐	☐	☐
6) Feeling bad about yourself or that you are a failure, or have let your family down	☐	☐	☐	☐
7) Trouble concentrating on things, such as reading or watching television	☐	☐	☐	☐
8) Moving or speaking so slowly that other people could have noticed; or being so fidgety or restless that you have being moving around a lot more than usual	☐	☐	☐	☐
9) Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

Interpretation

☐ Minimal Depression
☐ Mild Depression
☐ Moderate Depression
☐ Moderately Severe Depression
☐ Severe Depression

Total score:_____

Interpretation Scale for Depression Severity (total score)

* **1-4 Minimal Depression**
* **5-9 Mild Depression**
* **10-14 Moderate Depression**
* **15-19 Moderately Severe Depression**
* **20-27 Severe Depression**