Banner Health®

NEW PATIENT MEDICAL HISTORY - ADULT

Patient Name: _____ **Date of Birth:** _____

Please provide as much detail as you are able so that we can give you the safest and best care possible.

Where were you getting your care before? _____

Preferred Pharmacy (name and location): _____

What is the primary reason for your visit? #1: _____ #2 _____

If time permits, #3 _____

Specific requests: ❑ **Form completion** ❑ **Test result** ❑ **Referral** ❑ **Work/school excuse** ❑ **Med refill**
❑ **Other:** _____

Do you have: Advance Directive ❑ Yes ❑ No Living will ❑ Yes ❑ No Medical Power of Attorney ❑ Yes ❑ No

If no, would you like additional information? ❑ Yes ❑ No

ALLERGIES

List any allergies and intolerances to **medications, food or the environment.**

Allergy:	Reaction:

MEDICATIONS

List any medications you are taking, with dose and how often. Use the back of form for additional medication.

Medication Name:	Dose:	How often?	Refill needed (Y/N)?

List any Vitamins, Supplements and Over the Counter Medicines

1.	**4.**
2.	**5.**
3.	**6.**

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(01/2017)

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VACCINES

List the last date given:

Flu:	Tdap (tetanus and /or diphtheria):
Pneumococcal:	Zoster (Shingles):

DIAGNOSTIC TESTS

Enter last completion date and whether the result was normal.

TEST:	DATE:	NORMAL (Y/N):	TEST:	DATE:	NORMAL (Y/N):
Bone Density:			Pap Smear (Female Only)		
Colonoscopy:			PSA (Male Only):		
Mammogram (Female Only):					

Females Only:

Last Menstrual Period: _____ Normal? Yes ____ No ____ # of Pregnancies _____ # of Births _____

MEDICAL HISTORY

What **medical** problems have you had? Please mark **all** that apply:

	CONDITION:	ONSET DATE:		CONDITION:	ONSET DATE:		CONDITION:	ONSET DATE:
	Allergies			Coronary artery disease			Irritable bowel disease	
	Anemia			Dementia			Memory impairment	
	Angina			Depression			Myocardial infraction	
	Anxiety			Diabetes			Osteoporosis	
	Arthritis			Elevated lipids			Parkinson's disease	
	Asthma			Gallbladder disease			Renal disease	
	Atrial fibrillation			GERD			Seizure disorder	
	Blood clots			Headache, migraine			Stroke	
	Cancer			Heart disease			Thyroid disease	
	Cardiac arrhythmia			Heart valve disorder			Renal disease	
	COPD			Hepatitis / liver disease			Memory impairment	

Other medical problems:

_____

_____

Have you had any recent hospitalizations or ER visits (provide dates and reason below)?

Date:	Reason:	Date:	Reason:

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SURGICAL HISTORY

What **surgeries** have you had? Please mark **all** that apply and include the year they were performed.

	CONDITION:	DATE:		CONDITION:	DATE:		CONDITION:	DATE:
	Angioplasty			Carpal Tunnel			Hip replacement	
	Angioplasty w/ stent			Cataract Extraction			Knee replacement	
	Appendectomy			Cholecystectomy (Gallbladder removal)			Lasik	
	Arthroscopy			Colectomy (Colon removal)			Liver biopsy	
	Back surgery			Colostomy			Thyroidectomy	
	Blood transfusion			Gastric bypass			Tonsillectomy	
	Cardiac Pacemaker			Hernia repair				

Male specific:

	Prostate biopsy			Transurethral resection			Vasectomy	

Female specific:

	Bilateral tubal ligation			Breast biopsy			Hysterectomy	
	Breast augmentation			Cesarean Section			Mastectomy	
	Breast reduction			Dilation and Curettage			Myomectomy	

Other surgeries: _____

_____

FAMILY HISTORY

List health conditions for each family member.

	Alive	Deceased	Age of Death	Health Condition(s)
Father				
Mother				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Brothers				
Sisters				

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SOCIAL HISTORY

Married _____ Widowed _____ Divorced _____ Single _____ Significant Other _____

Occupation _____ Employer _____

Living arrangement: Home _____ Apartment _____ Skilled Nursing Facility _____ Other: _____

Do you have a pet? _____

Do you exercise? No _____ Yes _____ Type(s) _____ Hours per Week _____

Do you have any religious belief that could affect your medical care? _____

TOBACCO / ALCOHOL / CAFFEINE / DRUGS

Tobacco/smoking status: Never _____

Current _____ Type _____ Amount _____ Duration _____

Former _____ Type _____ Amount _____ Duration _____

Do you use alcohol? No _____ Yes _____ Type _____ Amount _____ Frequency _____

Do you use Caffeine? No _____ Yes _____ Type _____ Amount _____ Frequency _____

Do you use recreational drugs? No _____ Yes _____ Type _____ Amount _____ Frequency _____

QUALITY OF LIFE

In past 2 weeks, have you had little interest or pleasure in doing things?

Not at all (0) _____ Several days (1) _____ More than half the days (2) _____ Nearly every day (3) _____

In past 2 weeks, have you been feeling down, depressed or hopeless?

Not at all (0) _____ Several days (1) _____ More than half the days (2) _____ Nearly every day (3) _____

FALLS RISK ASSESSMENT

Have you fallen in the last year? No ____ Yes ____ If yes, number of falls? _____

Did the fall(s) result in an injury? No ____ Yes ____

CARE PROVIDERS

List any Specialist you see and reason.

Name	Specialty	Reason for Seeing Provider

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REVIEW OF SYSTEMS

In the **last thirty days,** have you experienced any of the following:

CONSTITUTIONAL			GASTROINTESTINAL			PSYCHIATRIC		
Chills	Yes	No	Abdominal pain	Yes	No	Anxiety	Yes	No
Fatigue/Weakness	Yes	No	Black tarry stools	Yes	No	Depression	Yes	No
Fever	Yes	No	Constipation	Yes	No	Insomnia	Yes	No
Night sweats	Yes	No	Diarrhea	Yes	No	**SKIN**		
Weight gain	Yes	No	Heartburn or reflux	Yes	No	Contact allergy	Yes	No
Weight loss	Yes	No	Loss of appetite	Yes	No	Itchy skin	Yes	No
HEENT			Nausea	Yes	No	Poor wound healing	Yes	No
Blurred/Double vision	Yes	No	Vomiting	Yes	No	Rash	Yes	No
Difficulty swallowing	Yes	No	**GENITOURINARY**			Skin infections/sores	Yes	No
Ear drainage	Yes	No	Blood in urine	Yes	No	**MUSCULOSKELETAL**		
Ear pain	Yes	No	Frequent urination	Yes	No	Back pain	Yes	No
Eye drainage	Yes	No	Pain with urination	Yes	No	Joint pain	Yes	No
Eye pain	Yes	No	Urinary incontinence	Yes	No	Joint swelling	Yes	No
Hearing loss	Yes	No	**Female**			Muscle weakness	Yes	No
Nasal drainage	Yes	No	Heavy periods	Yes	No	Neck pain	Yes	No
Vision changes	Yes	No	Painful periods	Yes	No	**HEMATOLOGIC**		
Vision loss	Yes	No	Vaginal discharge	Yes	No	Bleeding tendencies	Yes	No
RESPIRATORY			**Male**			Blood clots	Yes	No
Cough	Yes	No	Penile discharge	Yes	No	Easy bruising	Yes	No
Shortness of breath	Yes	No	**METABOLIC/ENDOCRINE**			**IMMUNOLOGICAL**		
TB exposure	Yes	No	Cold intolerance	Yes	No	Environmental allergies	Yes	No
Wheezing	Yes	No	Excessive hunger	Yes	No	Food allergies	Yes	No
CARDIOVASCULAR			Excessive thirst	Yes	No	Seasonal allergies	Yes	No
Calf pain with walking	Yes	No	Hair loss	Yes	No			
Chest pain	Yes	No	Heat intolerance	Yes	No			
Heart murmur	Yes	No	**NEUROLOGICAL**					
Irregular heartbeat	Yes	No	Difficulty walking	Yes	No			
Leg swelling	Yes	No	Dizziness	Yes	No			
Syncope (fainting)	Yes	No	Poor coordination	Yes	No			
			Memory loss	Yes	No			
			Seizures	Yes	No			
			Tremors	Yes	No			

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