Banner Health®

NEW PATIENT MEDICAL HISTORY
BEHAVIORAL HEALTH

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.

Preferred Pharmacy (name and location): _____

Primary Care Provider

Name: _____ Phone #: _____

Address: _____ Fax #: _____

Referring Provider: _____

ALLERGIES

❑ **No Known Allergies** List any allergies and intolerances to **medications, food or the environment.**

Allergy	Reaction

MEDICATIONS

❑ **No Medications** List any medications you are taking, with dose and how often.

Medication Name	Dose	How often?

List any Vitamins, Supplements and Over the Counter Medicines

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

DO NOT RETAIN AS PART OF THE PERMANENT MEDICAL RECORD

9999-0136
(01/2017)

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MEDICAL / PSYCHIATRIC HISTORY

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

	CONDITION		CONDITION		CONDITION		CONDITION
	ADD/ADHD		Bronchitis		Intermittent Explosive Disorder		Post-traumatic Stress Disorder (PTSD)
	Abdominal pain		Circadian rhythm disorder (sleep phase syndrome)		Major Depression-chronic		Prematurity
	Acne		Chickenpox		Major Depression-single episode		Psychotic Disorder
	Adjusted disorder with anxiety		Concussion/CHI		Menstrual Problems		Pyelonephritis
	Adjusted disorder with conduct disorder		Congenial Heart Disease		Migraines		Recurrent Depression Psychosis
	Adjustment disorder with depression		Constipation		Mood Disorder		Recurrent Otis Media
	Adjustment disorder with disturbance of emotions		Depression		Narcolepsy		Schizoaffective Disorder
	Allergic rhinitis		Diabetes		Obsessive Compulsive Disorder		Seizure Disorder
	Allergies		Drug Dependence		Oppositional Defiant Disorder		Seizure-Febrile
	Anemia		Dysthymic Disorder		Panic Disorder w/ agoraphobia		Sleep apnea
	Anxiety		Eczema		Panic Disorder w/o agoraphobia		Social Phobia
	Bipolar I		Fracture		Paranoid Schizophrenia		Substance Dependence
	Bipolar II		G.E.R.D.		Parasomnias		Suicidality
	Bleeding Disorder		Headache, migraine		REM _____ Non REM _____		Traumatic brain injury
	Borderline Personality Disorder		Hearing Problems		Pneumonia		Urinary tract infection
	Bronchiolitis		Heart murmur		Poly-substance Dependence		Other: _____

Other medical problems:

_____

SURGICAL HISTORY

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

	Adenoidectomy		Hypospadias repair		Tonsillectomy
	Appendectomy		Inguinal hernia repair		Umbilical hernia repair
	Circumcision		Lymph node biopsy		
	Dental surgery		PET placement		

Other surgeries: _____

_____

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FAMILY HISTORY

List health conditions for each family member.

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

SOCIAL HISTORY

TOBACCO / ALCOHOL / CAFFEINE / DRUGS
(For patients 12 and older)

Tobacco/smoking status: Never _____

Current _____ Type _____ Amount _____ Duration _____

Former _____ Type _____ Amount _____ Duration _____

Tobacco use in the household? ❑ Yes ❑ No

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

Alcohol use in the household? ❑ Yes ❑ No

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

Substance abuse use in the household? ❑ Yes ❑ No

TOBACCO / ALCOHOL / CAFFEINE / DRUGS
(For patients under 12)

Tobacco use in the household? ❑ Yes ❑ No

Alcohol use in the household? ❑ Yes ❑ No

Substance abuse use in the household? ❑ Yes ❑ No

HOME ENVIRONMENT

Child lives with: _____

EXERCISE

Do you exercise? ❑ Yes ❑ No If yes, list type of exercise and number of times/week: _____

EMPLOYMENT/SCHOOL

Grade in school: _____ Name of school: _____

Occupation _____ Employer _____

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REVIEW OF SYSTEMS

CONSTITUTIONAL			CARDIOVASCULAR			NEUROLOGICAL		
Headaches	**Yes**	**No**	Heart trouble	**Yes**	**No**	Frequent or recurring headaches	**Yes**	**No**
Recent weight gain	**Yes**	**No**	Palpitations	**Yes**	**No**	Head injury	**Yes**	**No**
Recent weight loss	**Yes**	**No**	Sudden heart beat changes	**Yes**	**No**	Stroke	**Yes**	**No**
EYES			**RESPIRATORY**			Tremors	**Yes**	**No**
Eye disease/injury	**Yes**	**No**	Asthma	**Yes**	**No**	**PSYCHIATRIC**		
Glaucoma	**Yes**	**No**	COPD	**Yes**	**No**	Depression	**Yes**	**No**
ENT			Use oxygen	**Yes**	**No**	Memory loss or confusion	**Yes**	**No**
Hearing loss	**Yes**	**No**	Wheezing	**Yes**	**No**	Nervousness	**Yes**	**No**
GENITOURINARY			**GASTROINTESTINAL**			Sleep problems	**Yes**	**No**
Frequent urination	**Yes**	**No**	Gastroesophageal reflux	**Yes**	**No**	**ENDOCRINE**		
Incontinence or dribbling	**Yes**	**No**	Loss of appetite	**Yes**	**No**	Glandular/hormone problem	**Yes**	**No**
Sexual difficulty	**Yes**	**No**	Nausea/Vomiting	**Yes**	**No**	Thyroid disease	**Yes**	**No**
MUSCULOSKELETAL						**HEMATOLOGIC**		
Back pain	**Yes**	**No**				Easily bruised/bleed	**Yes**	**No**
Difficulty walking	**Yes**	**No**						
Weakness of muscles/joints	**Yes**	**No**						

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