Banner Health®

NEW PATIENT MEDICAL HISTORY
CARDIOLOGY

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: ______________________________

Referring Doctor: ______________________________

Do you have an advance directive? ❑ Yes ❑ No

ALLERGIES

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

Allergy:	Reaction:

MEDICATIONS

❑ Not taking any medications

List any medications, vitamins, supplements, and over the counter medications you are taking, with dose and how often.

Medication Name	Dose	How often?

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MEDICAL HISTORY

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

	CONDITION:	ONSET DATE:		CONDITION:	ONSET DATE:		CONDITION:	ONSET DATE:
	Allergies			COPD			High cholesterol	
	Anemia			Coronary artery disease			Hypertension	
	Angina (chest pain)			Depression			Irritable bowel disease	
	Anxiety			Diabetes			Myocardial infraction	
	Arthritis			Gallbladder disease			Osteoarthritis	
	Asthma			GERD (reflux)			Prostate enlargement	
	Atrial fibrillation			Headache, migraine			Renal (kidney) disease	
	Blood clots			Heart attack			Seizure disorder	
	Cancer (list type):			Heart disease			Stroke	
	Cardiac arrhythmia			Hepatitis / liver disease			Thyroid disease	

Other medical problems:

HOSPITALIZATIONS

❑ No prior hospitalizations/ER visits List any recent hospitalizations or ER visits (provide dates and reason below)?

Date	

SURGICAL HISTORY

❑ No prior surgeries List all prior surgeries and the date.

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:								
	Augmentation mammoplasty			Cesarean Section			Mastectomy	
	Bilateral tubal ligation			Dilation and Curettage			Myomectomy	
	Breast biopsy			Hysterectomy			Reduction Mammoplasty	

Other surgeries: ______________________

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FAMILY HISTORY

List health conditions for each family member.

	Alive	Deceased	Age of Death	Health Condition(s)
Mother				
Father				
Sister				
Brother				
Daughter				
Son				

SOCIAL HISTORY

Tobacco/smoking status:	❑ Never				
	❑ Current	Type	Amount	Duration	
	❑ Former	Type	Amount	Duration	
Do you use alcohol?	❑ No	❑ Yes	Type	Amount	Frequency
Do you use recreational drugs?	❑ No	❑ Yes	Type	Amount	Frequency
Do you use Caffeine?	❑ No	❑ Yes	Type	Amount	Frequency

How many people other than you reside in your household? ❑ Spouse ❑ Children ❑ Grandparents ❑ Other: ____________

Marital Status: ❑ Married ❑ Divorced ❑ Single ❑ Widowed

Occupation: ____ Employer: ____

Do you exercise? ❑ Yes ❑ No If yes, list type and number of hours per week ________________________________

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REVIEW OF SYSTEMS

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

CONSTITUTIONAL			GASTROINTESTINAL			PSYCHIATRIC		
Fatigue	Yes	No	Abdominal pain	Yes	No	Anxiety	Yes	No
Recent fever	Yes	No	Constipation	Yes	No	Depression	Yes	No
Weight gain	Yes	No	Change in stools	Yes	No	Insomnia	Yes	No
Weight loss	Yes	No	Frequent diarrhea	Yes	No	Memory loss	Yes	No
HEENT			Loss of appetite	Yes	No	**SKIN**		
Ear drainage	Yes	No	Nausea	Yes	No	Discoloration	Yes	No
Ear pain	Yes	No	Vomiting	Yes	No	Hair loss	Yes	No
Eye discharge	Yes	No	**GENITOURINARY**			Itching	Yes	No
Eye pain	Yes	No	Blood in urine	Yes	No	Rash	Yes	No
Headache	Yes	No	Burning / pain with urination	Yes	No	Skin lesion	Yes	No
Hoarseness	Yes	No	Frequent urination	Yes	No	Varicose veins	Yes	No
Mouth sores	Yes	No	Incontinence	Yes	No	**MUSCULOSKELETAL**		
Nasal drainage	Yes	No	Kidney stones	Yes	No	Back pain	Yes	No
Nose bleeds	Yes	No	Sexual difficulty	Yes	No	Joint pain	Yes	No
Recent hearing loss	Yes	No	**METABOLIC/ENDOCRINE**			Joint stiffness/swelling	Yes	No
Sinus pressure	Yes	No	Cold intolerance	Yes	No	Muscle pain	Yes	No
Sore throat	Yes	No	Diabetes Type: ___________________	Yes	No	Weakness	Yes	No
Vision changes	Yes	No				**HEMATOLOGIC**		
RESPIRATORY			Excessive sweating	Yes	No	Anemia	Yes	No
Asthma	Yes	No	Excessive thirst	Yes	No	Easy bruising	Yes	No
Cough	Yes	No	Heat intolerance	Yes	No	Excessive bleeding	Yes	No
Shortness of breath	Yes	No	Weight loss	Yes	No	Past blood transfusion	Yes	No
Wheezing	Yes	No	**NEUROLOGICAL**			Phlebitis	Yes	No
CARDIOVASCULAR			Difficulty walking	Yes	No	Swollen glands	Yes	No
Chest pain	Yes	No	Dizziness	Yes	No			
Heart trouble	Yes	No	Headaches	Yes	No			
Irregular heartbeat	Yes	No	Numbness	Yes	No			
Swelling of feet, ankles or hands	Yes	No	Paralysis	Yes	No			
			Seizures	Yes	No			
			Stroke	Yes	No			
			Tremors	Yes	No			

Do you have or have you had any illness not previously referred to in this questionnaire? If yes, explain: _______________

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