Banner Health

NEW PATIENT MEDICAL HISTORY
ENDOCRINOLOGY

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 #: _____

What is the primary reason for your visit? _____

ALLERGIES

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

Allergy:	**Reaction:**

MEDICATIONS

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

❑ Not taking any medications

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

IMMUNIZATION

Have you had an influenza vaccine for this year? ❑ Yes ❑ No If yes, date: _____

DIAGNOSTIC/LAB TESTS

Enter last completion date and whether the result was normal.

TEST:	**DATE:**	**NORMAL (Y/N):**	**TEST:**	**DATE:**	**NORMAL (Y/N):**
Bone Density:			Colonoscopy:		

Date of last HbA_1c: _____ Result: _____

DO NOT RETAIN AS PART OF THE PERMANENT MEDICAL RECORD

9999-0149
(02/2018)

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Females Only:

Last Menstrual Period: _____ Normal? No _____ Yes _____

# of Pregnancies _____ # of Births _____

MEDICAL HISTORY

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

	Anxiety		Depression		Heart failure		Obstructive sleep apnea
	Asthma		Diabetes type: _____		High cholesterol		Osteoarthritis
	Atrial fibrillation		Emphysema/bronchitis		High blood pressure		Rheumatoid arthritis
	Brain aneurysm		Head injury		Irregular heart beat		Seizures / epilepsy
	Coronary artery disease		Heart attack		Neuropathy		Stroke / TIA
	Dementia						

Other medical problems:

_____

_____

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

Date:	Reason:	Date:	Reason:

SURGICAL HISTORY

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

Date	Type of Surgery	Date	Type of Surgery

FAMILY HISTORY

List health conditions for each family member.

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

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SOCIAL HISTORY

Occupation _____ Employer _____

Exercise? No ____ Yes ____ Type(s) _____ Hours per Week _____

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

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

REVIEW OF SYSTEMS

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

CONSTITUTIONAL			**GASTROINTESTINAL**			**MUSCULOSKELETAL**		
Fatigue	**Yes**	**No**	Abdominal pain	**Yes**	**No**	Fracture	**Yes**	**No**
Good general health	**Yes**	**No**	Constipation	**Yes**	**No**	Height loss	**Yes**	**No**
Recent weight gain	**Yes**	**No**	Diarrhea	**Yes**	**No**	Muscle cramps	**Yes**	**No**
Recent weight loss	**Yes**	**No**	Loss of appetite	**Yes**	**No**	Muscle loss	**Yes**	**No**
HEENT			Nausea	**Yes**	**No**	Muscle weakness	**Yes**	**No**
Bad breath/taste	**Yes**	**No**	Vomiting	**Yes**	**No**	**SKIN**		
Blurred/Double vision	**Yes**	**No**	**GENITOURINARY**			Excess body hair	**Yes**	**No**
Trouble swallowing	**Yes**	**No**	Frequent urination	**Yes**	**No**	Hair loss	**Yes**	**No**
Voice change	**Yes**	**No**	**HEMATOLOGIC**			Rash	**Yes**	**No**
RESPIRATORY			Easily bruise/bleed	**Yes**	**No**	**NEUROLOGICAL**		
Shortness of breath	**Yes**	**No**	**ENDOCRINE**			Frequent or recurring headaches	**Yes**	**No**
CARDIOVASCULAR			Excessive thirst	**Yes**	**No**	Light headed or dizzy	**Yes**	**No**
Chest pain	**Yes**	**No**	Heat or cold intolerance	**Yes**	**No**	Tremor/shaking hands	**Yes**	**No**
Swelling of feet/ankles/hands	**Yes**	**No**				Numbness/burning/tingling of feet or fingers	**Yes**	**No**

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