Banner Health®

NEW PATIENT MEDICAL HISTORY
GENERAL SURGERY

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? _____

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

Date:	Reason:	Date:	Reason:

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.

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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9999-0120
(01/2017)

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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			Chronic pain			Heart valve disorder	
	Anemia			COPD			Hepatitis / liver disease	
	Angina (chest pain)			Coronary artery disease			Hypertension	
	Anxiety			Depression			Irritable bowel disease	
	Arthritis			Diabetes			Myocardial infraction	
	Asthma			Elevated lipids			Osteoporosis	
	Atrial fibrillation			Fibromyalgia			Radiation treatment	
	Blood clots			Gallbladder disease			Renal disease	
	Cancer (list type): _____			GERD			Seizure disorder	
	Cardiac arrhythmia			Headache, migraine			Stroke	
	Chronic Fatigue			Heart disease			Thyroid disease	

Other medical/psychiatric problems: _____

Injuries without surgery: _____

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 type: _____				

Male specific:

	Prostate biopsy			Transurethral resection			Vasectomy	

Female specific:

	Bilateral tubal ligation			Breast reduction			Hysterectomy	
	Breast augmentation			Cesarean Section			Mastectomy	
	Breast biopsy			Dilation and Curettage (D&C)			Myomectomy	

Other surgeries: _____

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FAMILY HISTORY

Mother ____ Alive ____ Deceased (age at death) _____ Cause of Death _____

Medical problems _____

Father ____ Alive ____ Deceased (age at death) _____ Cause of Death _____

Medical problems _____

Siblings Number of Brothers _____ Number of Sisters _____ Medical problems _____

Children Number of Sons _____ Number of Daughters _____ Medical problems _____

Any additional pertinent family history: _____

SOCIAL HISTORY

Occupation _____ Employer _____

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

Do you have advance directives? _____

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 recreational drugs? No _____ Yes _____ Type _____ Amount _____ Frequency _____

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

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Review of Systems

CONSTITUTIONAL			SKIN			NEUROLOGICAL		
Drenching night sweats	Yes	No	Bad breath/taste	Yes	No	Frequent or recurring headaches	Yes	No
Fever	Yes	No	Breast discharge	Yes	No	Head injury	Yes	No
Fatigue	Yes	No	Breast lump	Yes	No	Light headed or dizzy	Yes	No
Good general health	Yes	No	Breast pain	Yes	No	Numbness/tingling sensations	Yes	No
Headaches	Yes	No	Bleeding gums	Yes	No	Paralysis	Yes	No
Recent weight loss	Yes	No	Change in skin color	Yes	No	Range of motion limit	Yes	No
EYES			Change in hair/nails	Yes	No	Stroke	Yes	No
Blurred/Double vision	Yes	No	Rash/itching	Yes	No	Tremors	Yes	No
Cataracts	Yes	No	Sore throat	Yes	No	**PSYCHIATRIC**		
Eye disease/injury	Yes	No	Swollen neck glands	Yes	No	Depression	Yes	No
Glaucoma	Yes	No	Varicose veins	Yes	No	Memory loss or confusion	Yes	No
Macular degeneration	Yes	No	Voice change	Yes	No	Nervousness	Yes	No
Wear glasses/contacts	Yes	No	**CARDIOVASCULAR**			Sleep problems	Yes	No
ENT			Chest pain	Yes	No	**ENDOCRINE**		
Earaches/Drainage	Yes	No	Heart trouble	Yes	No	Change in hat or glove size	Yes	No
Hearing loss	Yes	No	Sudden heart beat changes	Yes	No	Dry skin	Yes	No
Mouth sores	Yes	No	Swelling of feet/ankles/hands	Yes	No	Excessive thirst	Yes	No
Nose bleeds	Yes	No	**RESPIRATORY**			Glandular/hormone problem	Yes	No
Ringing in the ears	Yes	No	Frequent coughing	Yes	No	Heat or cold intolerance	Yes	No
Sinus problems	Yes	No	Shortness of breath	Yes	No	Thyroid disease	Yes	No
GENITOURINARY			Spitting up blood	Yes	No	**HEMATOLOGIC**		
Blood in urine	Yes	No	Use oxygen	Yes	No	Easily bruise/bleed	Yes	No
Burning/Painful urination	Yes	No	Wheezing	Yes	No	Enlarged glands	Yes	No
Change in strain when urinating	Yes	No	**GASTROINTESTINAL**			Inflammation of vein(s)	Yes	No
Frequent urination	Yes	No	Bloody/tarry stools	Yes	No	Slow to heal after cuts	Yes	No
Incontinence or dribbling	Yes	No	Change in bowel movements	Yes	No			
Kidney stones	Yes	No	Constipation	Yes	No			
Sexual difficulty	Yes	No	Diarrhea	Yes	No			
MUSCULOSKELETAL			Distended abdomen	Yes	No			
Back pain	Yes	No	History of familial polyps	Yes	No			
Cold extremities	Yes	No	History of ulcerative colitis/ diverticulitis	Yes	No			
Difficulty walking	Yes	No	Loss of appetite	Yes	No			
Joint pain	Yes	No	Nausea/Vomiting	Yes	No			
Joint stiffness/swelling	Yes	No	Ostomy	Yes	No			
Muscle pain/cramps	Yes	No	Stomach pain	Yes	No			
Weakness of muscles/joints	Yes	No						

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