Banner Health

NEW PATIENT HISTORY FORM

Name: **Date of Birth:** **Today's Date:**

How did you hear about us?

Who is your **Primary Care Provider** (MD/NP/PA)?

What is your **preferred pharmacy?**

1. What is the **reason for your visit today?**

2. Are you **allergic to latex?** ☐ Yes ☐ No

3. If you have **medication allergies**, please complete the following:

Medication	Reaction

4. **Medications.**
Please list all current prescription medications. Include the dosage and frequency.

Medication Name	Dosage	Frequency Taken

5. **Pregnancy History**.
How many **times have you been pregnant** (include miscarriages and abortions)?
How many **full term births** have you had (37 to 40 weeks)?
How many **preterm births** have you had (before 37 weeks)?
How many **C-sections?** How many **vaginal births?**
How many **miscarriages** have you had? How many **abortions?**
How many **stillbirths?** How many **ectopic pregnancies?**
How many **natural living children** do you have?

Did you have any **pregnancy complications?** ☐ Yes ☐ No If Yes, please list below:

Pregnancy #	Complication

6. **Gynecological History.**
What **method of contraception** do you use?
How old were you when you **started having menstrual periods?**
What was the **FIRST day of your last menstrual period?**
How often do your **menstrual periods** occur?
Are your periods ☐ **light** ☐ **moderate** ☐ **heavy?** Do you have **cramps** with your periods? ☐ Yes ☐ No
If yes, what do you **take to relieve the pain** from the cramps?
If you are **post-menopausal**, was your menopause ☐ **natural** or ☐ **surgical?**
Since menopause, have you had **any vaginal bleeding?** ☐ Yes ☐ No
Do you have **hot flashes?** ☐ Yes ☐ No **night sweats?** ☐ Yes ☐ No **vaginal dryness?** ☐ Yes ☐ No
When was your last **Pap Smear?** **Any abnormal Pap Smears?** ☐ Yes ☐ No
When was your **last mammogram?** **When** was your **last bone density?**

7. **Sexual History.**
Are you **presently sexually active?** ☐Yes ☐No Do you have sex with ☐ men ☐ women ☐ both?
How many sexual partners do you **currently** have? **How many lifetime sexual partners** have you had?
Do you **practice safe sex?** ☐ abstinence ☐ condoms ☐ mutual monogamy
Do you have a **history** of ☐ chlamydia ☐ gonorrhea ☐ HIV ☐ syphilis
☐ hepatitis B or C ☐ herpes ☐ trichomoniasis ☐ HPV?

8. **Chronic Medical Problems.**
Do you have any **chronic medical problems** that **require ongoing treatment or medication?**

Medical Problem	Year Diagnosed	Health Provider

9. **Past Medical History.**
If you have **ever had** any of the following **medical conditions**, please mark and put year diagnosed:

☐ Anemia
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation
☐ Autoimmune Disorder
☐ Blood Clots
☐ Blood Transfusion
☐ Breast Problems
☐ Cancer
☐ Cardiovascular Disease
☐ COPD
☐ Crohn's Disease
☐ Cystic Fibrosis
☐ Diabetes
☐ Gallbladder Disease
☐ GERD
☐ Heart Attack
☐ Hepatitis
☐ High Cholesterol
☐ High Blood Pressure
☐ Injuries (Trauma/Violence)
☐ Infertility
☐ Irritable Bowel Syndrome
☐ Liver Disease
☐ Migraine Headaches
☐ Osteoporosis
☐ Peptic Ulcer Disease
☐ Psychiatric Disorder
☐ Renal (Kidney) Disease
☐ Thyroid Disorder
☐ Varicose Veins
☐ Other
☐ Other

10. **Past Surgical History.**
Please include the **type of surgery** you have had and list the **year performed**.

Surgery	Year Performed

11. **Family History.**
Please list **any history** for your **mother, father, siblings, children, grandparents, aunts, and uncles.**

Medical Condition	Family Member and Age Diagnosed
Breast Cancer	
Ovarian Cancer	
Colon Cancer	
Uterine Cancer	
Diabetes	
Heart Disease	
High Blood Pressure	
Stroke	
Blood Clots	
Other	

12. **Social History.**
Marital Status:
Occupation: **Full-time?** ☐ Yes ☐ No ☐ Retired
Highest Level of Education: **Degree** earned:
Number of people in your **household:**
Tobacco use? ☐ Yes ☐ No ☐ Former **Units per day:**
Alcohol use? ☐ Yes ☐ No ☐ Former **Frequency:**
Caffeine use? ☐ Yes ☐ No **Type:** **Amount daily:**
Exercise? ☐ Yes ☐ No **Type:** **Hours per week:**

13. **Review of Systems.**
Please mark any of the following **symptoms** you have **experienced recently.**

☐ Chills
☐ Fatigue
☐ Fever
☐ Malaise
☐ Night sweats
☐ Weight gain
☐ Weight loss

☐ Ear drainage
☐ Ear pain
☐ Eye discharge
☐ Hearing loss
☐ Nasal drainage
☐ Sinus pressure
☐ Sore throat
☐ Visual changes

☐ Chronic cough
☐ Cough
☐ TB exposure
☐ Short of breath
☐ Wheezing

☐ Chest pain
☐ Claudication
☐ Edema
☐ Palpitations

☐ Abdominal pain
☐ Blood in stools
☐ Change in stools
☐ Constipation
☐ Diarrhea
☐ Heartburn
☐ Loss of appetite
☐ Nausea
☐ Vomiting

☐ Painful urination
☐ Blood in urine
☐ Increased urination
☐ Urinary incontinence
☐ Urinary retention

☐ Abnormal Pap
☐ Breast discharge
☐ Breast lump
☐ Painful Periods
☐ Painful Intercourse
☐ Hot flashes
☐ Irregular menses
☐ Vaginal discharge

☐ Brittle hair
☐ Brittle nails
☐ Cold intolerance
☐ Heat intolerance
☐ Excessive thirst
☐ Excessive hunger

☐ Dizziness
☐ Numbness
☐ Gait disturbance
☐ Headache
☐ Memory loss
☐ Seizures
☐ Tremors

☐ Anxiety
☐ Depression
☐ Insomnia

☐ Contact allergy
☐ Hives
☐ Itching
☐ Mole changes
☐ Rash
☐ Skin lesion

☐ Back pain
☐ Joint pain
☐ Joint swelling
☐ Weakness
☐ Neck pain

☐ Easy bleeding
☐ Easy bruising
☐ Swollen nodes

☐ Allergies
☐ Food allergies
☐ Hay fever