Banner Health

NEW PATIENT MEDICAL HISTORY
BEHAVIORAL HEALTH

Patient Name: ______________________________ **Date of Birth:** ______________

Gender Identity (Optional) ______________________________

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 #: ______________

Referring Provider: ______________________________ Phone #: ______________

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, including any Psychiatric medications. Please include dose and how often they are taken.

Medication Name	Dose	How often?

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List any Vitamins, Supplements and Over the Counter Medicines

1.	**2.**
3.	**4.**

MEDICAL / PSYCHIATRIC HISTORY

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

	CONDITION		CONDITION		CONDITION		CONDITION
	ADD/ADHD		Circadian rhythm disorder (sleep phase syndrome)		Intermittent Explosive Disorder		Post-traumatic Stress Disorder (PTSD)
	Abdominal pain		Chickenpox		Major Depression-chronic		Prematurity
	Acne		Concussion/CHI		Major Depression-single episode		Psychotic Disorder
	Adjusted disorder with anxiety		Congenial Heart Disease		Menstrual Problems		Pyelonephritis
	Adjusted disorder with conduct disorder		Constipation		Migraines		Recurrent Depression Psychosis
	Adjustment disorder with depression		Depression		Mood Disorder		Recurrent Otis Media
	Adjustment disorder with disturbance of emotions		Diabetes		Narcolepsy		Schizoaffective Disorder
	Allergic rhinitis		Drug Dependence		Obsessive Compulsive Disorder		Seizure Disorder
	Allergies		Dysthymic Disorder		Oppositional Defiant Disorder		Seizure-Febrile
	Anemia		Eating 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 REM ______ Non REM _____		Suicidality/Homicide ideations
	Bleeding Disorder		Headache, migraine				Traumatic brain injury
	Borderline Personality Disorder		Hearing Problems		Past Psychiatric Hospitalizations		Urinary tract infection
	Bronchiolitis		Heart murmur		Pneumonia		Other: ____________________
	Bronchitis		History of Counseling/ Therapy		Poly-substance Dependence		

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				
Siblings				

SOCIAL HISTORY

TOBACCO / ALCOHOL / CAFFEINE / DRUGS

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
Recreational drug use/abuse in the household?	❑ Yes	❑ No			

HOME ENVIRONMENT

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Number of Children: __________

If Applicable, Child lives with: ______________________________

EXERCISE

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

EMPLOYMENT/SCHOOL

Highest grade in school completed: __________ 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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