Banner Health®

NEW PATIENT CHECK-IN FORM

SAFA SPECIALTY CLINICS

925 East McDowell Rd, 3rd Floor Phoenix AZ 85006

Specialty _____

Patient Name _____ Date of Birth _____ Preferred Language _____	**For Internal Use Only** Height _____ Weight _____ Blood Pressure _____ Pulse _____ Temp _____ Resp _____

Guardian / Support Role (if appropriate)

Name _____ Relationship _____ Role: ___Next of Kin ___ Guardian ___Caregiver

Who is your Primary Care Physician / Family Doctor? _____Tel____ _____

Who is the doctor who referred you to our practice? _____ Tel _____

Please provide as much detail as you are able so that we can give you the safest and best care possible.

Please provide your preferred pharmacy name and location

_____

_____

What are you here for today? _____

Are you here for an injury? Please circle Yes or No What date did this injury happen? _____

MEDICATIONS

Please list any medications you are taking, with dose and frequency.

Medication	Dosage	# Times a Day	Do you need refills?
_____	_____ _____	_____	No____ Yes____
_____	_____ _____	_____	No ____ Yes____
_____	_____ _____	_____	No ____ Yes____
_____	_____ _____	_____	No ____ Yes____
_____	_____ _____	_____	No ____ Yes____
_____	_____ _____	_____	No ____ Yes____
_____	_____ _____	_____	No ____ Yes____
_____	_____ _____	_____	No ____ Yes____
_____	_____ _____	_____	No ____ Yes____
_____	_____ _____	_____	No ____ Yes____

00-0251
(01/2015)

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Patient Name _____ **Date of Birth** _____

MEDICATIONS (cont'd)

Please list Vitamins, Supplements and Over the Counter Medicines

_____

_____

_____

_____

_____

_____

ALLERGIES

Please list any allergies and intolerances to **medications**

Allergy	**Reaction**
_____	_____
_____	_____
_____	_____

Do you have an Egg, Neomycin or Gelatin allergy? No____ Yes____

Do you have an allergy to intravenous contrast? No____ Yes____

Please list any allergies to **food** or the **environment**

Allergy	**Reaction**
_____	_____
_____	_____
_____	_____

Males & Females	**Females Only**
Last Colonoscopy Date _____ Normal? No____ Yes____	Last Pap Date _____ Normal? No____ Yes____
Last Cholesterol Date _____ Normal? No____ Yes____	History of Abnormal Pap? No____ Yes____
Males Only	Last Bone Density Date _____ Normal? No____ Yes____
Last PSA Date _____ Normal? No____ Yes____	Last Mammogram Date _____ Normal? No____ Yes____

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REVIEW OF SYSTEMS (MALE PATIENTS ONLY)

Please indicate if you are experiencing any of the following:

Constitutional

___ Chills
___ Fatigue
___ Fever
___ Malaise
___ Night Sweats
___ Weight Gain
___ Weight Loss

HEENT

___ Ear Drainage
___ Ear Pain
___ Eye Discharge
___ Eye Pain
___ Hearing Loss
___ Nasal Drainage
___ Sinus Pressure
___ Sore Throat
___ Visual Changes

Respiratory

___ Chronic Cough
___ Cough
___ Known TB Exposure
___ Shortness of Breath
___ Wheezing

Cardiovascular

___ Chest Pain
___ Pain in Legs with Walking
___ Swelling
___ Palpitations

Gastrointestinal

___ Abdominal Pain
___ Blood in Stools
___ Change in Stools
___ Constipation
___ Diarrhea
___ Heartburn
___ Loss of Appetite
___ Nausea
___ Vomiting

Genitourinary

___ Dribbling
___ Pain with urination
___ Blood in urine
___ Polyuria
___ Slow Stream
___ Urinary Frequency
___ Urinary Incontinence
___ Urinary Retention

Reproductive

___ Erectile Dysfunction
___ Penile Discharge
___ Sexual Dysfunction

Metabolic / Endocrine

___ Brittle Hair
___ Brittle Nails
___ Cold Intolerance
___ Hair Changes
___ Heat Intolerance
___ Increased Hair Growth
___ Increased Thirst
___ Increased Hunger

Neurological

___ Dizziness
___ Extremity Numbness
___ Extremity Weakness
___ Gait Disturbance
___ Headache
___ Memory Loss
___ Seizures
___ Tremors

Psychiatric

___ Anxiety
___ Depression
___ Insomnia

Integumentary

___ Contact Allergy
___ Hives
___ Itching
___ Mole Changes
___ Rash
___ Skin Lesion

Musculoskeletal

___ Back pain
___ Joint Pain
___ Joint Swelling
___ Muscle Weakness
___ Neck Pain

Hematologic/Lymphatic

___ Easy Bleeding
___ Easy Bruising
___ Swollen Lymph Nodes / Glands

Immunologic

___ Environmental Allergies
___ Food Allergies
___ Seasonal Allergies

REVIEW OF SYSTEMS (FEMALE PATIENTS ONLY)

Please indicate if you are experiencing any of the following:

Constitutional

___ Chills
___ Fatigue
___ Fever
___ Malaise
___ Night Sweats
___ Weight Gain
___ Weight Loss

HEENT

___ Ear Drainage
___ Ear Pain
___ Eye Discharge
___ Eye Pain
___ Hearing Loss
___ Nasal Drainage
___ Sinus Pressure
___ Sore Throat
___ Visual Changes

Respiratory

___ Chronic Cough
___ Cough
___ Known TB Exposure
___ Shortness of Breath
___ Wheezing

Cardiovascular

___ Chest Pain
___ Pain in Legs with Walking
___ Edema
___ Palpitations

Gastrointestinal

___ Abdominal Pain
___ Blood in Stools
___ Change in Stools
___ Constipation
___ Diarrhea
___ Heartburn
___ Loss of Appetite
___ Nausea
___ Vomiting

Genitourinary

___ Pain with urination
___ Blood in urine
___ Polyuria
___ Urinary Frequency
___ Urinary Incontinence
___ Urinary Retention

Reproductive

___ Abnormal Pap
___ Breast Discharge
___ Breast Lump
___ Painful Periods
___ Painful Intercourse
___ Hot Flashes
___ Irregular Periods
___ Vaginal Discharge

Metabolic / Endocrine

___ Brittle Hair
___ Brittle Nails
___ Cold Intolerance
___ Hair Changes
___ Heat Intolerance
___ Increased Hair Growth
___ Increased Thirst
___ Increased Hunger

Neurological

___ Dizziness
___ Extremity Numbness
___ Extremity Weakness
___ Gait Disturbance
___ Headache
___ Memory Loss
___ Seizures
___ Tremors

Psychiatric

___ Anxiety
___ Depression
___ Insomnia

Integumentary

___ Contact Allergy
___ Hives
___ Itching
___ Mole Changes
___ Rash
___ Skin Lesion

Musculoskeletal

___ Back pain
___ Joint Pain
___ Joint Swelling
___ Muscle Weakness
___ Neck Pain

Hematologic/Lymphatic

___ Easy Bleeding
___ Easy Bruising
___ Swollen Lymph Nodes / Glands

Immunologic

___ Environmental Allergies
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MEDICAL HISTORY

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

___Allergies	___Prostate Enlargement	___Depression	___Irritable Bowel
___Anemia	___Blood Clots	___Diabetes	___Liver Disease
___Angina	___Cancer (type)_____	___Gallbladder Disease	___Migraines
___Anxiety	___Stroke	___GERD – Reflux	___Heart Attack
___Arthritis	___COPD	___Hepatitis C	___Osteoarthritis
___Asthma	___Heart Disease	___High Cholesterol	___Ulcers
___Atrial Fibrillation	___Crohn's Disease	___Hypertension	___Kidney Disease
___Seizure Disorder	___Thyroid Disease		

Other medical problems: _____

_____

SURGICAL HISTORY

What **surgeries** have you had? Please mark **all** that apply and include the year they were performed.

___Angioplasty_____	___Gallbladder Removal_____	___Thyroidectomy_____
___Angio w/Stent_____	___Gastric Bypass_____	___Tonsillectomy_____
___Appendectomy_____	___Hernia Repair_____	___Hysterectomy_____
___Arthroscopic Knee_____	___Heart Bypass_____	___Prostate Biopsy_____
___Back Surgery_____	___Knee Replacement_____	___TURP (Prostate)_____
___Bowel Resection_____	___LASIK_____	___Vasectomy_____
___Carpal Tunnel_____	___Liver Biopsy_____	___Cataract Extraction_____
___Pacemaker_____	___Tubal Ligation_____	___ Thyroid Biopsy _____

Men Only

___Prostate Biopsy_____	___Transurethral Resection_____	___Vasectomy_____

Women Only

___Augmentation Mammoplasty_____	___Bilateral Tubal Ligation_____	___Breast Biopsy_____
___Cesarean Section_____	___Dilation and Curettage _____	___Hysterectomy_____
___Mastectomy_____	___Myomectomy_____	___ Reduction Mammoplasty _____
___TAH/BSO_____	___Vaginal Hysterectomy_____	

Other surgeries: _____

Have you had any recent hospitalizations or ER visits?

_____

_____

_____

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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 _____

Have any of the women in your family had a heart attack/heart disease at age 65 or younger? No___ Yes ___

Have any of the men in your family had a heart attack/heart disease at age 55 or younger? No___ Yes ___

Any additional pertinent family history _____

SOCIAL HISTORY

Marital Status _____ Occupation _____ Employer _____

Exercise? Yes___ Type _____ Hours per Week _____

How many people other than you reside in your household? ___Spouse ___Children ___Grandparents ___Other

Do you have advance directives? _____

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

TOBACCO / ALCOHOL / CAFFEINE / DRUGS

Please check your current tobacco status.

_____ I currently use tobacco Type/Amount/Years:_____

_____ I no longer use tobacco Type/Amount/Years:_____

_____ I have never used tobacco

Do you use alcohol? No ___ Yes___ Type _____ Amount _____ Frequency_____

Do you use Caffeine? No ___ Yes___ Type _____ Amount _____ Frequency_____

Do you use Illicit Drugs? No ___ Yes___ Type _____ Amount _____ Frequency_____

OTHER

Do you use contraceptives? No ___ Yes___Type _____

Who is your dentist? _____ Telephone _____

Do you have any dental / oral problems? _____

Have you had any radiation exposure? _ _____

RECENT HISTORY

Please list your most recent Healthcare Provider(s) _____

How did you hear about us? _____

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