Banner Health

NEW PATIENT MEDICAL HISTORY
MOVEMENT DISORDER

Patient name: _____ Date of Birth: _____ Today's date _____

Gender Identity (optional): ❑ Male ❑ Female ❑ Other: _____

Who referred you? _____

Primary Care Provider

Name: _____ Phone # _____

Address: _____ Fax #: _____

Preferred Pharmacy (name and location): _____

Reason for visit: _____

ALLERGIES

❑ No known allergies. List any allergies and intolerances to medications, food or the environment.

Allergy:	Reaction:

MEDICATIONS

❑ Not taking any medications

List any medications, vitamins, supplements and over the counter medicines you are taking

Medication Name:	Dose:	Times they are taken:

MEDICAL HISTORY

List any current or past medical conditions (please place check mark by any current problems).

DO NOT RETAIN AS PART OF THE PERMANENT MEDICAL RECORD

9999-0150
(12/2023)

Banner Health

NEW PATIENT MEDICAL HISTORY
MOVEMENT DISORDER

Patient Name _____ Date of Birth _____

FAMILY HISTORY

(particularly note those conditions relevant to why you are here; list family member and diagnosis):

	Alive	Deceased	Age of Death	Health Condition(s)
Father				
Mother				
Brothers				
Sisters				

SOCIAL HISTORY

Tobacco (please fill out all blanks unless you never used tobacco):

❑ Yes ❑ No ❑ Former Type? _____ How much? _____ # years use _____

Alcohol

❑ Yes ❑ No ❑ Former Type? _____ How much? _____ # years use _____

Were you ever a heavy drinker? _____

Any recreational drug use (if yes, please describe)? _____

What type of employment did/do you do? _____

Level of education _____

Retired when? _____ Disability? _____

Hobbies? _____

Exercise? How much, what type and how often? _____

_____

Do you have any assistive devices? ❑ Walker ❑ Wheel Chair ❑ Cane ❑ Braces (of any kind)

How often and where do you use this? _____

Marital status: _____ Number of children: _____ Which hand do you write with? _____

DO NOT RETAIN AS PART OF THE PERMANENT MEDICAL RECORD

9999-0150
(12/2023)

Banner Health

NEW PATIENT MEDICAL HISTORY
MOVEMENT DISORDER

Patient Name _____ Date of Birth _____

REVIEW OF SYSTEMS

PLEASE REVIEW THIS AND CHECK APPROPRIATELY ANY SYMPTOMS THE PATIENT IS EXPERIENCING CURRENTLY OR IN THE PAST

CONSTITUTIONAL	CURRENT	PAST	GENITOURINARY	CURRENT	PAST	PSYCHIATRIC	CURRENT	PAST
Chills			Dribbling			Anxiety		
Fatigue			Burning with urination			Depression		
Fever			Blood in urine			Insomnia		
Malaise (general discomfort)			Excessive urination			Any other sleep disturbances		
Night Sweats			Slow Stream					
Weight Gain			Urinary Frequency			**SKIN**		
Weight Loss			Urinary Incontinence			Contact Allergy		
			Urinary Retention			Hives		
HEENT						Itching		
(HEAD, EYES, EARS,			**REPRODUCTIVE**			Mole Changes		
NOSE, THROAT)			Erectile Dysfunction (men)			Rash		
Ear Drainage			Penile/Vaginal Discharge			Skin Lesion		
Ear Pain			Sexual Dysfunction					
Eye Discharge			Abnormal Pap Smear (women)			**MUSCULO-SKELETAL**		
Eye Pain			Breast discharge or lump (women)			Back Pain		
Hearing Loss			Painful menstrual periods (women)			Joint Pain		
Nasal Drainage			Pain with intercourse			Joint Swelling		
Sinus Throat			Hot flashes (women)			Muscle Weakness		
Visual Changes			Irregular menstrual periods (women)			Neck Pain		
RESPIRATORY			**METABOLIC/ENDO**			**HEMATOLOGIC/LYMPHATIC**		
Chronic Cough			Brittle Hair			Easy Bleeding		
Cough			Brittle Nails			Easy Bruising		
Known TB Exposure			Cold intolerance			Swollen glands		
Shortness of Breath			Hair changes					
Wheezing			Heat intolerance			**IMMUNOLOGIC**		
Asthma			Excessive Hair Growth			Environmental Allergy		
			Excessive thirst			Food Allergy		
CARDIOVASCULAR			Excessive eating			Seasonal Allergy		
Chest Pain								
Leg pain with walking			**NEUROLOGICAL**					
Edema			Dizziness					
Palpitations (abnormal heart beats)			Extremity Numbness					
			Extremity Weakness					
GASTRO-INTESTINAL			Walking or Balance Problems					
Abdominal Pain			Headache					
Blood in Stools			Memory Loss					
Change in Stools			Seizures/Convulsions					
Constipation			Tremors					
Diarrhea			Sudden Loss of Consciousness					
Heartburn								
Loss of appetite								
Nausea								
Vomiting								

DO NOT RETAIN AS PART OF THE PERMANENT MEDICAL RECORD

9999-0150
(12/2023)