Crossroads Health Center, LLC

NAME:_____ **DATE:**____/____/____

BIRTHDATE:____/____/____ **AGE:**_____

REASON FOR VISIT: ☐ **ROUTINE PHYSICAL** ☐ **PROBLEM** **DESCRIBE PROBLEM:** _____
_____

CHECK IF YOU HAD ANY OF THESE MEDICAL PROBLEMS IN THE PAST:

MAJOR ILLNESSES	YES	NO		YES	NO
Anemia			Emphysema		
Anxiety			Gastric Intestinal Bleed		
Arthritis / Joint pain			Heart Attack		
Asthma			Heart Murmur		
Back Problems			Hepatitis/Jaundice		
Blood Infusions			High Cholesterol		
Bowel Trouble			Hypertension		
Brain Aneurysm*			Hyperthyroid		
Cancer			Hypothyroid		
Breast			Kidney Stones		
Colon			Lupus		
Lung			Mood Disorder		
Prostate			M.S.		
Chronic Obstructive Pulmonary Disease			Osteoporosis		
Chronic Recurrent Cough			Pneumonia		
Colon Polyps			Prosthetic		
Diabetes Mellitus			Rheumatoid Arthritis		
Type I Age of Onset			Sinus Problems		
Type II Age of Onset			Sexually Transmitted Disease		
Dialysis (Kidney Failure)			Stroke		
Diverticulitis			Ulcers		

WHEN WAS YOUR LAST TEST OR IMMUNIZATION?

	DATE		DATE
Abnormal PAP Smear		Tetanus	
Bone Density		Mammogram	
Colonoscopy / Sigmoidoscopy		Last PAP Smear	
Flu Shot		TB Skin Test	
Pneumonia		OTHER:	

PLEASE LIST ANY OPERATIONS OR HOSPITALIZATIONS YOU HAVE HAD:

SURGERY / REASON	DATE	SURGERY / REASON	DATE

PLEASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

DRUG NAME	DOSAGE	PHYSICIAN	DRUG NAME	DOSAGE	PHYSICIAN

ALLERGIES TO MEDICATIONS / SUBSTANCES (LATEX GLOVES, ETC.?)	List:

Patient Name:_____ **Date of Birth:**_____

CIRCLE AND CHECK IF YOUR BLOOD RELATIVES HAVE HAD:

MAJOR ILLNESSES	YES	NO	**WHAT BLOOD RELATIVE?**
Asthma			
Brain Aneurysm			
Cancer			
Breast			
Colon			
Lung			
Prostate			
Colon Polyps			
Diabetes Mellitus			
Type I Age of Onset			
Type II Age of Onset			
Dialysis (Kidney Failure)			
Heart Attack			
High Cholesterol			
Hypertension			
Mood Disorder			
Stroke			
Other:			

YOUR GYN HISTORY

Do you use birth control? ☐ Yes ☐ No	
❑ Condoms	❑ Nuvaring
❑ Depo Provera	❑ Birth Control Patch
❑ Diaphragm	❑ None
❑ IUD- Kind	❑ Natural Family Plan/Rhythm
- Date Inserted:	❑ Tubal Ligation
❑ Birth Control Pill	❑ Vasectomy
– Name:	❑ Withdrawal
❑ Contraceptive Foam/Jelly	❑ Other:
What age did you have your first period: _____	
How long does your period last?_____ days	Flow: ☐ Light ☐ Medium ☐ Heavy
Date of Last Period: _____	
Have you gone thru Menopause: ☐ Yes ☐ No	At what age: _____
Are you on Hormone Replacement Therapy (hormones)?	☐ Yes ☐ No

YOUR OB HISTORY

	NUMBER		NUMBER
Total # of Pregnancies		# of Births	
# of Vaginal Deliveries		Abortions Induced	
# of C-Sections		Living Children	
Miscarriages			