CROSSROADS MEDICAL GROUP
A LifeBridge Health Medical Group

ACCOUNT #: ___________________

PATIENT MEDICAL HISTORY FORM

PATIENT NAME *Last* *First* *Middle*			DATE OF BIRTH	GENDER M F BIRTH GENDER M F
HOME PHONE #	WORK PHONE #	CELL PHONE #		
EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE #	RELATIONSHIP TO PATIENT		
MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED		IF MARRIED, SPOUSE'S NAME		
CHILDREN'S NAMES & AGES				

DO YOU HAVE ALLERGIES TO ANY MEDICATIONS, X – RAYS, OR OTHER SUBSTANCES? ☐YES ☐NO
IF YES, PLEASE LIST NAME(S) OF MEDICINE(S) AND TYPE(S) OF REACTION:

PAST MEDICAL HISTORY AND REVIEW OF SYMPTOMS: PLEASE CHECK IF YOU HAVE HAD ANY PROBLEMS IN THE PAST OR ARE CURRENTLY COMPLAINING OF ANY OF THE FOLLOWING CONDITIONS OR SYMPTOMS.

☐ HIGH BLOOD PRESSURE	☐ ASTHMA	☐ ULCERS
☐ DIABETES	☐ BRONCHITIS	☐ CHANGES IN BOWEL HABITS
☐ CANCER	☐ RHEUMATIC FEVER	☐ LOW BACK PROBLEMS
☐ CHEST PAIN/TIGHTNESS	☐ GALLBLADDER DISEASE	☐ HEMORRHOIDS
☐ SHORTNESS OF BREATH	☐ ANXIETY	☐ COLITIS
☐ SWOLLEN ANKLES	☐ DEPRESSION	☐ HEPATITIS/JAUNDICE
☐ PALPITATIONS	☐ ALCHOHOL ABUSE	☐ FREQUENT URINATION
☐ LIGHTHEADEDNESS	☐ DRUG ABUSE	☐ KIDNEY DISEASE
☐ HEADACHES	☐ UNEXPLAINED WEIGHT GAIN/LOSS	☐ KIDNEY STONES
☐ HEAD / NECK RADIATION	☐ NAUSEA	☐ DIFFICULTY URINATING
☐ ARTHRITIS	☐ VOMITING	☐ THYROID DISEASE
☐ GOUT	☐ INDIGESTION	☐ BLOOD DISORDERS
☐ PNEUMONIA	☐ ABDOMINAL DISCOMFORT	☐ ANEMIA
☐ PERSISTENT COUGH	☐ CONSTIPATION	☐ SKIN DISEASES
☐ TUBERCULOSIS (TB)	☐ DIARRHEA	☐ OTHER
☐ HAY FEVER	☐ BLOOD IN STOOL	

DESRCIBE ALL CHECKED ITEMS:

DID YOU HAVE ANY UNUSUAL CHILDHOOD ILLNESSES? ☐**YES** ☐**NO**
IF SO, PLEASE EXPLAIN:____

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SURGICAL HISTORY

PLEASE LIST ANY SURGERIES YOU HAVE UNDERGONE AND THE APPROXIMATE DATE OR YEAR:

TYPE OR OPERATION	DATE

PLEASE LIST ANY HOSPITALIZATIONS YOU HAVE UNDERGONE, OTHER THAN SURGERY, AND THE APPROXIMATE DATE OR YEAR:

HOSPITALIZATION REASON	DATE

HAVE YOU HAD ANY PROBLEMS WITH ANESTHESIA IN THE PAST? ▢**YES** ▢**NO**

IMMUNIZATION HISTORY: HAVE YOU HAD

TETATUS/DIPTHERIA or TETANUS/DIPTHERIA/PERTUSSIS IMMUNIZATION	▢YES ▢NO	WHEN
PNEUMOVAX (PNEUMONIA VACCINATION)	▢YES ▢NO	
HEPATITS B IMMUNIZATION	▢YES ▢NO	
FLU (INFLUENZA) FLU	▢YES ▢NO	
SHINGLES VACCINATION (ZOSTAVAX)	▢YES ▢NO	
OTHER	▢YES ▢NO	

HAVE YOU EVER HAD THE FOLLOWING ILLNESSES (APROXIMATELY WHAT AGE) – CHICKENPOX; MUMPS; MEASLES?

____

PLEASE INDICATE THE APROXIMATE DATES OF YOUR LAST TEST IF APPLICABLE:

MAMMOGRAM		PAP SMEAR		BREAST EXAM	
COLONOSCOPY		STOOL TEST		PROSTATE EXAM	
CHOLESTEROL CHECK		EYE EXAM		CHEST X - RAY	
BONE DENSITY (DEXA)		EKG		STRESS TEST	

SOCIAL HISTORY:

DO YOU USE TOBACCO PRODUCTS?	▢YES ▢NO	WHAT TYPE & HOW MANY PER DAY?
DO YOU DRINK ALCOHOL?	▢YES ▢NO	HOW MANY DRINKS PER DAY/WEEK?
DO YOU WEAR SEATBELTS?	▢YES ▢NO	ALWAYS USUALLY NEVER
DO YOU DRINK CAFFEINATED BEVERGES?	▢YES ▢NO	WHICH TYPE & HOW MANY PER DAY/WEEK?
DO YOU USE STREET DRUGS?	▢YES ▢NO	WHICH TYPE & HOW OFTEN?
ARE YOU SEXUALLY ACTIVE?	▢YES ▢NO	DO YOU USE CONTRACEPTIVES? WHAT TYPE?
DO YOU FOLLOW ANY SPECIAL DIET? (SOUTH BEACH, LOW CARB/FAT/SODIUM)	▢YES ▢NO	WHICH ONE?

SOCIAL HISTORY (continued):

WHAT IS YOUR RACE/ETHNICITY? ___________________WHERE WERE YOU BORN? ______________________

WHAT IS YOUR OCCUPATION? HOURS PER WEEK? ARE THERE ANY STRENOUS OR HARMFUL JOB-RELATED CONDITIONS? (EXPOSURE TO ASBESTOS, CHEMICALS, PAINTS OR OTHER HAZARDOUS MATERIALS)?

____

DO YOU EXERCISE REGULARLY? IF SO, WHAT TYPES OF PHYSICAL ACTIVITY AND HOW OFTEN?____

HAVE YOU EVER ENGAGED IN ANY ACTIVITY THAT HAS PUT YOU AT RISK FOR AIDS? ▢**YES** ▢**NO**

EXPLAIN: ____

DO YOU HAVE A GUN IN YOUR HOUSE? DO YOU KEEP IT UNLOADED & OUT OF CHILDREN'S REACH? ▢**YES** ▢**NO** ▢**DO NOT OWN A GUN**

ARE YOU IN A RELATIONSHIP IN WHICH YOU HAVE BEEN PHYSICALLY HURT(slapped, kicked, punched, bruised etc.) BY YOUR PARTNER? ▢**YES** ▢**NO**

DO YOU EVER FEEL AFRAID OF YOUR PARTNER? ▢**YES** ▢**NO**

DO YOU HAVE A “LIVING WILL”? ▢**YES** ▢**NO** DO YOU HAVE A DONOR CARD? ▢**YES** ▢**NO**

WHAT IS YOUR HIGHEST LEVERL OF EDUCATION: ____

FAMILY HISTORY:

HAS ANY MEMBER OF YOUR FAMILY EVER HAD THE FOLLOWING ILLNESSES OR MEDICAL CONDITIONS? IF SO, PLEASE INDICATE WHICH FAMILY MEMBER (MOTHER, BROTHER, MATERNAL/PATERNAL GRANDFATHER ETC.). PLEASE SPECIFY IF THEY ARE LIVING OR DECEASED AND THE APROXIMATE AGE AT WHICH THEY DIED.

	FAMILY MEMBER	AGE	
CANCER (IF YES, WHICH TYPE)			▢LIVING ▢DECEASED
HYPERTENSION (HIGH BLOOD PRESSURE)			▢LIVING ▢DECEASED
HEART DISEASE			▢LIVING ▢DECEASED
HIGH CHOLESTEROL			▢LIVING ▢DECEASED
DIABETES (TYPE IF KNOWN)			▢LIVING ▢DECEASED
STROKE			▢LIVING ▢DECEASED
MENTAL ILLNESS (ANXIETY, DEPRESSION, ETC.)			▢LIVING ▢DECEASED
DRUG OR ALCOHOL ADDICTION			▢LIVING ▢DECEASED
GLAUCOMA			▢LIVING ▢DECEASED
BLEEDING DISEASE			▢LIVING ▢DECEASED
OSTEOPOROSIS or RHEUMATOID ARTHRITIS			▢LIVING ▢DECEASED
OTHER (SPECIFIY)			▢LIVING ▢DECEASED

MEDICATIONS: PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING OVER-THE-COUNTER MEDICATIONS, VITAMINS, HERBS ETC.

DRUG NAME	DOSE / FREQUENCY	DRUG NAME	DOSE / FREQUENCY