Crossroad

Crossroad Health Center New Patient Form

Name: _____ Date: _____ DOB_____

Gender: _____ (does this match your birth certificate? Y/N)

Are you using any prescribed medicines? Yes / No
Are you taking any other medicines (Tylenol or Laxatives) or vitamins or herbs? Yes / No

Circle any of the following that you have or have had in the past:

ARTHRITIS
ASTHMA
SEIZURES
DRUG USE
THYROID PROBLEMS
JAUNDICE
DEPRESSION
PELVIC INFECTION
DRINKING PROBLEM
GALL BLADDER PROBLEMS
HIGH BLOOD PRESSURE
STROKE
ABORTION

ATTEMPTED SUICIDE
STOMACH ULCERS
PHYSICAL ABUSE
SEXUAL ABUSE
BROKEN BONE
SICKLE CELL
HEAD INJURY
PNEUMONIA
HEART ATTACK
KIDNEY DISEASE
BLOOD IN STOOL
DIABETES (SUGAR)
MISCARRIAGE

ABNORMAL PAP SMEAR
SEXUALLY TRANSMITTED DISEASE
ABNORMAL VAGINAL BLEEDING
GLAUCOMA
HEART PROBLEM
CANCER
HEPATITIS
HIGH CHOLESTEROL
C-SECTION
SURGERY
EMPHYSEMA

Do you have any other medical problems or conditions? Yes / No
PLEASE SPECIFY:

Have you ever been a patient in a hospital? Yes / No
IF SO, WHY?

FAMILY HISTORY: Circle the following if any or your relatives ever had them:

ADD/ADHD
ALCOHOLISM
ALLERGIES
ASTHMA
CAD (HEART PROBLEMS)
CANCER
CVA (STROKE)

DEPRESSION
DIABETES
ECZEMA
HIGH CHOLESTEROL
HIGH BLOOD PRESSURE
MENTAL ILLNESS
MIGRAINES

OSTEOARTHRITIS
KIDNEY (RENAL) DISEASE
SEIZURES DISORDER
DRUG ADDICTION
SICKLE CELL (TRAIT)
SUICIDE

SOCIAL HISTORY:

Employment Status: __Employed __Unemployed __Disabled __Retired __Student __Minor

If employed, place of employment and occupation: _____

Persons living with you and relationship:

Ages of living children:_____ Have any died? Yes / No

Do you use tobacco? Yes / No

DOB_____

If so, what type? Cigarettes Smokeless tobacco E-cigarettes/Vaping Cigarillos

How many per day?

Do you drink alcohol? Yes / No If YES, how many drinks per week?

Do you use drugs? Yes/No If so, what and how often?

Were you sexually active in the past year? Yes No

If yes, were you sexually active with? (Circle all that apply) Men Women Transgender Both

How many different partners have you had in the last year? _____

How would your describe your sexual orientation? (circle one):

- ☐ Heterosexual/Straight
- ☐ Homosexual/Lesbian/Gay
- ☐ Bisexual
- ☐ Unsure
- ☐ Other
- ☐ Choose not to disclose

How would you describe your gender identity?(circle one):
Male Female Transgender Female/Transwoman/MTF Transgender Male/Transman/FTM
Other _____ Choose not to disclose

What sex were you assigned at birth? Male Female Decline to answer

Marital status (circle one): MARRIED SINGLE WIDOWED DIVORCED

Are you a veteran? Yes/No

Are you part of a particular faith or religious community? Yes/No

One of Crossroad's Guiding Principles is that we "promote the health of the whole person – body, mind and spirit, acknowledging God as the ultimate source of all health". Is your faith important to you in relationship to your health? Yes/No/Not sure

Please name any other concerns you may wish to share with your doctor and whether you would like us to pray with you:

_____