Crossroad Health Center Past Medical History

Name: Date of Birth:

Medical History:
Are you currently taking any prescribed medications? ☐ Yes ☐ No

Are you taking any other medicines (Tylenol or laxatives) or vitamins or herbs? ☐ Yes ☐ No

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

☐ Arthritis	☐ Attempted Suicide	☐ Abnormal Pap Smear
☐ Asthma	☐ Stomach Ulcers	☐ Sexually Transmitted Disease
☐ Seizures	☐ Physical Abuse	☐ Abnormal Vaginal Bleeding
☐ Drug Use	☐ Sexual Abuse	☐ Glaucoma
☐ Thyroid Problems	☐ Broken Bone	☐ Heart Problems
☐ Jaundice	☐ Sickle Cell	☐ Hepatitis
☐ Pelvic Infection	☐ Head Injury	☐ High Cholesterol
☐ Drinking Problem	☐ Pneumonia	☐ Blood in Stool
☐ Gall Bladder Problems	☐ Heart Attack	☐ Emphysema
☐ High Blood Pressure	☐ Kidney Disease	☐ C-Section
☐ Stroke	☐ Diabetes (sugar)	☐ Abortion
☐ Cancer	☐ Surgery	☐ Miscarriage
Type:	Type:	

Do you have any other medical problems or conditions? ☐ Yes ☐ No Please Specify:_____

Have you ever been a patient in a hospital? ☐ Yes ☐ No Please Specify:_____

FAMILY HISTORY: Please check if any of your relatives ever had any of the following:

☐ ADD/ADHD	☐ Depression	☐ Osteoarthritis
☐ Alcoholism	☐ Diabetes	☐ Kidney (Renal) Disease
☐ Allergies	☐ Eczema	☐ Seizure Disorder
☐ Asthma	☐ High Cholesterol	☐ Drug Addiction
☐ CAD (Heart Problems)	☐ High Blood Pressure	☐ Sickle Cell (Trait)
☐ CVA (Stroke)	☐ Mental Illness	☐ Suicide
☐ Cancer	☐ Migraines	

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Name: Date of Birth:

SOCIAL HISTORY:
How would you describe your sexual orientation?

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

How would you describe your gender identity?

☐ Male ☐ Female ☐ Transgender Female/Transwoman/MTF ☐ Transgender Male/Transman/FTM ☐ Other: _____
☐ Choose not to disclose

What are your pronouns? ☐ he/him ☐ she/her ☐ they/them ☐ Other:_____

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

Do you use tobacco? ☐ Yes ☐ No ☐ Former user 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: (Check all that apply) ☐ Men ☐ Women ☐ Transgender

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

Are you a 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."

Do you have faith in God or consider yourself a spiritual person? ☐ Yes ☐ No ☐ Other:_____

Is your faith important to you? ☐ Yes ☐ No ☐ Other:_____

Are you part of a spiritual community? ☐ Yes ☐ No ☐ Other:_____

How can we be helpful to you in your spiritual journey?

_____

_____

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

Crossroad Health Center Initial Prenatal Visit History Form

Past Pregnancy History

	Date of Delivery	Miscarriage, abortion, vaginal delivery or C-Section	Weeks at Delivery	Male(M) or Female(F)	Weight of baby	Problems during Pregnancy	Birth Hospital
1							
2							
3							
4							
5							
6							

Past Medical History Please check any of the following that you have or have had in the past

☐ Diabetes (sugar)	☐ Depression
☐ High Blood Pressure	☐ Liver disease
☐ Heart disease	☐ Thyroid disease
☐ Autoimmune disease	☐ Blood transfusion
☐ Kidney disease	☐ Asthma
☐ Seizures	☐ Complications with anesthesia

Genetic History Please check any of the following that you, the baby's father, or anyone in either family has had

☐ Neural tube defect (i.e. spina bifida)	☐ Familial dysautonomia
☐ Thalassemia	☐ Sickle cell disease or trait
☐ Recurrent pregnancyu loss or stillbirth	☐ Hemophilia
☐ Other inherited genetic disorder	☐ Muscular dystrophy
☐ Congenital heart defect	☐ Cystic fibrosis
☐ Down syndrome	☐ Hungtinton's disease/chorea
☐ Tay-sachs disease	☐ Mental retardation/disability
☐ Canavan disease	☐ Autism

Crossroad Health Center Initial Prenatal Visit History Form

Women's Health History

☐ Preterm labor	☐ Postpartum depression
☐ Preeclampsia	☐ Breast surgery
☐ C-section	☐ Gynecologic surgery (on cervix, uterus, ovary)
☐ Rh sensitization	☐ Abnormal Pap smear
☐ Postpartum bleeding	☐ Infertility
☐ Gestational diabetes	☐ Polycystic ovarian syndrome (PCOS)

Infection History

☐ TB or around someone with TB	☐ Chlamydia
☐ Genital herpes (yourself or partner)	☐ Syphilis
☐ Hepatitis	☐ HIV
☐ Gonorrhea	☐ Recent travel outside the country

Does anyone in your immediate family (parents,brothers/sisters) have diabetes (sugar)?

☐ Yes ☐ No If yes, who? _____

Do you smoke? ☐ Yes ☐ No If so, how much per day? _____

Do you drink alcohol? ☐ Yes ☐ No If so, how many drinks per week? _____

Do you use any other drugs? ☐ Yes ☐ No If so, what? _____

Review of Systems Please check all problems you have today or in the past 2 weeks

☐ Weight loss/gain	☐ Abdominal pain	☐ Abnormal vaginal discharge
☐ Fatigue	☐ Constipation	☐ Breast pain
☐ Vision Changes	☐ Headache	☐ Breast mass/lump
☐ Chest pain	☐ Burning with urination	☐ Breast discharge
☐ Shortness of breath	☐ Vaginal bleeding	☐ Depressed mood/anxiety