

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:

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

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

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SOCIAL HISTORY:

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: