

CROSSROADS MEDICAL GROUP, PLLC

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GOODLETTSVILLE

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WHITE HOUSE

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NEW PATIENT MEDICAL HISTORY

Name Date of Birth Occupation

DRUG ALLERGIES

SURGICAL HISTORY

Drug/Reaction _____ Procedure/Date/Surgeon _____

Drug/Reaction _____ Procedure/Date/Surgeon _____

Drug/Reaction _____ Procedure/Date/Surgeon _____

FAMILY HISTORY

PERSONAL HABITS

	Father	Mother	Siblings	Father Parents	Mother's Parents
Alcoholism	-	-	-	-	-
Asthma	-	-	-	-	-
Bleeding Disorder	-	-	-	-	-
Cancer/Type _____	-	-	-	-	-
Diabetes	-	-	-	-	-
Epilepsy/Convulsions	-	-	-	-	-
Glaucoma	-	-	-	-	-
Hair Loss	-	-	-	-	-
Heart Disease	-	-	-	-	-
High Blood Pressure	-	-	-	-	-
Kidney Disease	-	-	-	-	-
Mental Illness	-	-	-	-	-
Migraine	-	-	-	-	-
Osteoporosis	-	-	-	-	-
Stroke	-	-	-	-	-
Thyroid Disease	-	-	-	-	-
Other _____	-	-	-	-	-

Alcohol
 Never
 Rarely
 Socially
 Daily

Exercise
 Never Rarely Occasionally Daily

Tobacco Use
 Never
 Packs per day _____
 How Long _____

FEMALE PATIENTS

Pregnancies _____ Live Births _____
 Miscarriages _____ Abortions _____
 Flushing/Menopause
 Last Pap test _____
 Normal Abnormal
 Last Mammogram _____
 Normal Abnormal

PERSONAL HISTORY

Date of Last

<input type="checkbox"/> Allergic Rhinitis/Hay Fever	<input type="checkbox"/> Diverticulosis/Diverticulitis	<input type="checkbox"/> Migraine	Colonoscopy _____
<input type="checkbox"/> Anemia	<input type="checkbox"/> Eczema	<input type="checkbox"/> Obesity	Echo _____
<input type="checkbox"/> Asthma/Wheezing	<input type="checkbox"/> Erectile Dysfunction	<input type="checkbox"/> Osteoporosis	EGD _____
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Gout	<input type="checkbox"/> Prostate Disease/BPH	EKG _____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Headaches	<input type="checkbox"/> Psoriasis	Immunizations Up to Date
<input type="checkbox"/> Back Pain/Recurrent	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Recurrent Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Bronchitis/Chronic Cough	<input type="checkbox"/> Hernia	<input type="checkbox"/> Seizures	Physical _____
<input type="checkbox"/> Cancer/Type _____	<input type="checkbox"/> Hepatitis/Type _____	<input type="checkbox"/> Stroke/ TIAs	PSA _____
<input type="checkbox"/> Crohn's/ <input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Dysfunction	Tetanus _____
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> History of Kidney Stones	<input type="checkbox"/> Ulcers	Stress Test _____
<input type="checkbox"/> COPD/Emphysema	<input type="checkbox"/> History of Sinus Trouble	<input type="checkbox"/> Urinary Incontinence	
<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Hyperlipidemia/ <input type="checkbox"/> Cholesterol	<input type="checkbox"/> Varicose Veins/Phlebitis	
<input type="checkbox"/> Depression	<input type="checkbox"/> Indigestion or Heartburn	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Other _____
<input type="checkbox"/> Diabetes (<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2)	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Poor Vision	<input type="checkbox"/> Other _____