CROSSROADS
MEDICAL GROUP PLLC

_____ _____
Name Date of Birth

DRUG ALLERGIES

Drug _____ Drug _____

Drug _____ Drug _____

PERSONAL / SURGICAL HISTORY

□Alcohol	□ Diabetes	□ Sleep Disorder
□Tobacco Use	□ Congestive Heart Failure	□ Depression
□ COPD/Emphysema	□ Coronary Artery Disease	□ Back Pain/Recurrent
□ Asthma/Wheezing	□ Atrial Fibrillation	□ Migraine/ Headaches
□ Hernia Repair	□ Heart Surgery	□ Seizures
□ Tonsillectomy	□ Appendectomy	□ Gall Bladder Removal

FEMALE PATIENTS Date of Last Period_____

Current Medications	**Strength**	**Number of times taken daily**
_____	_____	1 2 3 4
_____	_____	1 2 3 4
_____	_____	1 2 3 4
_____	_____	1 2 3 4
_____	_____	1 2 3 4
_____	_____	1 2 3 4
_____	_____	1 2 3 4
_____	_____	1 2 3 4
_____	_____	1 2 3 4
_____	_____	1 2 3 4