CROSSROADS
Medical Group

_____ _____
Name Date of Birth

DRUG ALLERGIES and Reactions

Drug _____ Drug _____

Drug _____ Drug _____

PERSONAL / SURGICAL HISTORY

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

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

Family History - List Medical history if available
A=Alive D=Deceased

Father: A or D _____
GrandMother: A or D _____
GrandFather: A or D _____
Siblings: Health Issues? _____

Mother: A or D _____
GrandMother: A or D _____
GrandFather: A or D _____
Children: Health Issues? _____

Social History- Y= Yes N= No
Smoke Y or N if Y how much daily _____
Drink Y or N if Y how much daily _____
Married Y or N
Exercise Y or N
Work _____