SILVER CROSS MEDICAL GROUP

The way you *should* be treated.

NEW PATIENT HEALTH HISTORY

Patient Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Have YOU ever had:
(CIRCLE ALL THAT ARE YES)

Arthritis
Asthma/COPD/Emphysema
Anemia or blood transfusion
Blood clots
Cancer (where? _____)
Colon problems
Depression/Anxiety
Diabetes
GERD/esophageal reflux
Glaucoma
Gout
Heart attack
High blood pressure
High cholesterol
Kidney disease/stones
Liver disease
Migraines
Osteoporosis/osteopenia
Phlebitis/vein disease
Stroke
Thyroid problem
Abnormal Pap
Abnormal mammogram
Other medical conditions/diseases not listed _____

Surgeries/Procedures
(CIRCLE ALL THAT ARE YES)

Appendix
Breast reconstruction
Breast lumpectomy
Bladder surgery
Cataract removal
Cesarean section
Colonoscopy
D & C
EGD (upper endoscopy)
Gallbladder
Gastric surgery
Heart valve replacement
Hysterectomy (ovaries Y/N?)
Joint replacement
Mastectomy R/L
Thyroid
Tonsillectomy
Transplant
Other procedures _____

Family History
(PLEASE STATE WHO HAD)

Alcoholism _____
Blood disease _____
Colon cancer _____
Diabetes _____
Heart attack _____
High blood pressure _____
High cholesterol _____
Mental illness _____
Migraines _____
Osteoporosis _____
Rheumatoid arthritis _____
Other _____

Gynecologic History:

How old at first period? _____ Last Period? _____

How long between periods? _____ How long do periods last? _____

Flow: ☐ Heavy ☐ Normal ☐ Light Cramps? ☐ Y ☐ N

Times Pregnant? _____ Miscarriages _____ Abortions _____ Live Births _____

Birth Control: _____

Sexually Active? ☐ Yes ☐ No

Allergies: _____

Marital Status: _____ **Occupation:** _____

Medications: _____

_____

What are your health concerns? _____