SILVER CROSS MEDICAL GROUP
The way you *should* be treated.

New Patient Health History

PATIENT NAME _____**DOB** _____ **Today's Date**_____

Have YOU ever had
(Circle All That Apply)

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

Surgeries/Procedures
(Circle All That Apply)

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

Family History
(Ex: Father, Mother, Maternal/Paternal Family)

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

Other medical conditions/diseases not listed _____

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 _____

Allergies _____ **Occupation** _____

Medications_____
_____
_____

What are your health concerns? _____