Crossville Medical Group

NAME:_____**DATE OF BIRTH:**_____

Previous provider:_____**Pharmacy:**_____

Medications: Please list or provide us with a copy of your current prescriptions or over the counter medications including vitamins, herbs, or inhalers. Use the back of this form for additional space if needed. ☐ **No medications.**

Medication	**Dose**	**How often**

Medication allergies: ☐ **NONE**_____

_____

Medical Problems: Have you had or do you have any of the following medical problems (please circle):

High blood pressure	Cancer	Asthma	Lung Disease	Tuberculosis
Heart Attack	Arthritis	Diabetes	Seizure disorder	HIV/AIDS
Heart Disease	Thyroid	Anemia	Blood transfusion	Kidney Disease
Stroke	Sickle Cell	STDs	Abnormal Pap	Urinary Tract Infection
Pancreas disorder	Liver disease/Hepatitis		Ulcer	Headaches

Family Medical History: Have any immediate family had or have any of the following, please circle.

Heart Disease	Cancer	Asthma	Severe Allergies	Diabetes
High Blood Pressure	Stroke		Thyroid Disease	

Surgeries/procedures: _____

_____

Immunizations: Have you had any of the following, please circle.

Influenza Pneumonia Covid