Cramer Family Clinic

Print Form

NEW PATIENT HEALTH HISTORY FORM

Patient Name: _____ **Birth date**: ____/____/____ **Date**: ____/____/_____

Pharmacy Name: _____ Phone Number: _____-_____-_____

Reason for today's visit:

_____

_____

_____

PRIOR SURGERIES	CURRENT/ PRIOR ILLNESSES/ INJURIES

Please list ALL medications (prescription and non- prescription) that you take. (Include herbal remedies, vitamins, over-the-counter, street drugs, prescriptions etc.)

MEDICATION	DOSAGE	MEDICATION	DOSAGE

Do you take any blood thinning products such as **Vitamin E, Plavix, Coumadin, or Aspirin**? ☐ **NO** ☐ **YES**

Do you have any food, environmental, or drug allergies? ☐ **NO** ☐ **YES** (Please explain below)

ALLERGY	TYPE	REACTION

Do you smoke? ☐ **NO** and Never have ☐ **YES** (Please explain below)

TYPE OF SMOKING (cigarette, pipe marijuana, chew, etc.)	HOW MUCH	HOW LONG

Do you drink alcohol? ☐ **NO** and Never have ☐ **Socially Only** ☐ **Daily** ☐ **Beer/ Wine** ☐ **Hard Liquor**

Occupation: _____ Hand Dominance: ☐ **RIGHT** ☐ **LEFT**

Please describe any family health issue below:

FAMILY HISTORY	GOOD/ NONE	UNKNOWN	ILLNESSES/ REASON FOR DEATH
MOTHER	☐	☐	
FATHER	☐	☐	
SIBLING(S)	☐	☐	
OTHER HEREDITARY ILLNESS	☐	☐	

Patient Signature: _____ **Date:** ____/_____/_____

Physician Signature: _____ **Date Reviewed:** ____/____/____

Cramer Family Clinic

HEALTH HISTORY FORM 2

Do you have or have you ever had any of the following:

Symptoms/ Illness	NO	YES, Explain	Symptoms/ Illness	NO	YES, Explain
Constitutional			**Skin**		
Fever or Chills	☐		Breast Abnormalities	☐	
Weight Loss	☐		Nipple Discharge	☐	
Hematologic			**Last Mammogram**		**Date: ____/____/____**
Hepatitis	☐		Changes in Moles	☐	
HIV/ Other Blood Diseases	☐		Lesions	☐	
Bleeding Disorders	☐		Rashes	☐	
Endocrine			History of Keloids	☐	
Thyroid Problems	☐		**Neurological**		
Diabetes	☐		Neurological Problems	☐	
Musculoskeletal			Headaches	☐	
Arthritis	☐		**GENITOURINARY**		
Mobility/ Joint Problems	☐		Genital or Oral Herpes	☐	
GASTROINTESTINAL			S.T.D.'s	☐	
Constipation	☐		Blood in Urine	☐	
Diarrhea	☐		Urinary Tract Infection	☐	
Blood in Stool	☐		Problems Urinating	☐	
Nausea/ Vomiting	☐		Prostate Problems	☐	
Liver Problems	☐		Kidney Problems	☐	
CARDIOVASCULAR			**Eyes**		
Heart Problems	☐		Vision Problems	☐	
Deep Vein Thrombosis/ DVT	☐		**ENT**		
Blood Clots in Lungs/ Legs	☐		Hearing Problems	☐	
High Blood Pressure	☐		Sinus Problems	☐	
RESPIRATORY			**PSYCHIATRIC**		
Asthma	☐		Mood Swings	☐	
Sleep Apnea	☐		Anxiety/ Depression	☐	

Please list any other conditions/ illnesses not indicated above: _____

_____

To the best of my knowledge, this information is complete and correct. I understand that it is my responsibility to inform my doctor if there are any changes to my health.

Patient Signature: _____ Date: ____/____/____

Physician Signature: _____ Date Reviewed: ____/____/____