

Stephanie K. Kraft M.D., P.C. – New Patient Health Questionnaire

Name: \_\_\_\_\_ Today's date: \_\_\_ / \_\_\_ / \_\_\_

Your date of birth: \_\_\_ / \_\_\_ / \_\_\_ How did you hear about us? \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Please list all ALLERGIES: \_\_\_\_\_

Please list all current and past significant health problems: \_\_\_\_\_

Please list all surgeries and hospitalizations: \_\_\_\_\_

Please list all prescription medications, including doses: \_\_\_\_\_ Reason for medication: \_\_\_\_\_


(Please continue your list on the back if necessary)

Please list all over-the-counter medications, herbs, vitamins, \_\_\_\_\_ Reason for medication: \_\_\_\_\_

and supplements: _____	

Please list the names of your other physicians: \_\_\_\_\_

Are you: single married/partnership divorced widowed Children? Y N # \_\_\_\_\_

Your occupation? \_\_\_\_\_ Women: how many pregnancies have you had? \_\_\_\_\_

Exercise habits? \_\_\_\_\_ Hobbies? \_\_\_\_\_

Do you smoke cigarettes, cigars, or a pipe? Yes Quit Never Eating habits? \_\_\_\_\_

Do you ever drink alcohol? Y N Amount: \_\_\_\_\_ For how long? \_\_\_\_\_

Do you ever use recreational drugs? Y N Type: \_\_\_\_\_

Have you ever used nasal cocaine or injected drugs? Y N \_\_\_\_\_

Do you have tattoos? Y N Date(s): \_\_\_\_\_

Do you think you have ever been exposed to HIV or hepatitis? Y N I'm not sure \_\_\_\_\_

Do you have an advanced directive (e.g. living will or medical durable power of attorney)? Y N \_\_\_\_\_

Stephanie K. Kraft M.D., P.C. – New Patient Health Questionnaire

Your last mammogram: \_\_\_/\_\_\_/\_\_\_  
 Your last colonoscopy: \_\_\_/\_\_\_/\_\_\_  
 Your last DEXA scan: \_\_\_/\_\_\_/\_\_\_

Your last Pap: \_\_\_/\_\_\_/\_\_\_  
 Your last prostate exam: \_\_\_/\_\_\_/\_\_\_  
 Your last annual physical: \_\_\_/\_\_\_/\_\_\_

Dates of last vaccinations:

Influenza \_\_\_/\_\_\_/\_\_\_  
 Tetanus/pertussis \_\_\_/\_\_\_/\_\_\_  
 Hepatitis A \_\_\_/\_\_\_/\_\_\_  
 Hepatitis B \_\_\_/\_\_\_/\_\_\_  
 Varicella \_\_\_/\_\_\_/\_\_\_ OR had chickenpox: Y N

Pneumovax \_\_\_/\_\_\_/\_\_\_  
 Prevnar13 \_\_\_/\_\_\_/\_\_\_  
 HPV \_\_\_/\_\_\_/\_\_\_  
 Shingrix \_\_\_/\_\_\_/\_\_\_

**Family History:** please circle the family members who have had the following:

Heart disease	Bro/Sis	Mother	Father	Grandmother	Grandfather	Child
Stroke	Bro/Sis	Mother	Father	Grandmother	Grandfather	Child
Blocked arteries in the legs	Bro/Sis	Mother	Father	Grandmother	Grandfather	Child
Cancer type: _____	Bro/Sis	Mother	Father	Grandmother	Grandfather	Child
_____						
Blood clots	Bro/Sis	Mother	Father	Grandmother	Grandfather	Child
Depression	Bro/Sis	Mother	Father	Grandmother	Grandfather	Child
Diabetes	Bro/Sis	Mother	Father	Grandmother	Grandfather	Child
High blood pressure	Bro/Sis	Mother	Father	Grandmother	Grandfather	Child
High cholesterol	Bro/Sis	Mother	Father	Grandmother	Grandfather	Child
Thyroid disease	Bro/Sis	Mother	Father	Grandmother	Grandfather	Child
Kidney disease	Bro/Sis	Mother	Father	Grandmother	Grandfather	Child
Hemochromatosis	Bro/Sis	Mother	Father	Grandmother	Grandfather	Child
Celiac disease	Bro/Sis	Mother	Father	Grandmother	Grandfather	Child
Sickle cell disease	Bro/Sis	Mother	Father	Grandmother	Grandfather	Child
Rheumatoid arthritis	Bro/Sis	Mother	Father	Grandmother	Grandfather	Child
Osteoporosis	Bro/Sis	Mother	Father	Grandmother	Grandfather	Child
Alcohol abuse	Bro/Sis	Mother	Father	Grandmother	Grandfather	Child
Other: _____	Bro/Sis	Mother	Father	Grandmother	Grandfather	Child

Thank you!