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, and supplements:	Reason for medication:

Please list the names of your other physicians:

Are you: single married/partnership divorced widowed	Children? Y N #_____ Women: how many pregnancies have you had?
Your occupation?	Hobbies?
Exercise habits?	Eating habits?
Do you smoke cigarettes, cigars, or a pipe? Yes Quit Never	Amount: For how long?
Do you ever drink alcohol? Y N	Amount:
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 ____/____/____
HPV ____/____/____
Varicella ____/____/____ OR had chickenpox: Y N
Shingrix ____/____/____, ____/____/____

Pneumonia:
Pneumovax23 ____/____/____
Prevnar13 ____/____/____
Prevnar20 ____/____/____
COVID19: how many doses? _____
Type(s)? _____
Dates, if known: _____

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!