Medical Information Form v2024.11 edition **Isaac Kramer, MD**

ALL SHADED FIELDS ARE REQUIRED

Your Name_______________________________________ **Today's Date**___________

Check the symptoms you currently have

□ weight gain □ weight loss □ fatigue □ dizziness □ headache	□ frequent pain in the abdomen □ black stool □ blood in the stool □ change in bowel habits □ heartburn	□ loss of consciousness □ tremors □ goiter □ thyroid disease □ anemia
□ hearing loss / ringing in the ears □ shortness of breath □ snoring □ persistent cough □ chest pain □ palpitations	□ gout □ back problems □ memory loss □ depression □ excessive stress □ mood changes	□ blood clots □ prostate disease □ frequent urination □ difficulty urinating □ kidney failure □ menopause

Do you have:

□ diabetes – since when?_____________ □ high cholesterol
□ hypertension □ chronic lung disease
□ heart disease □ cancer - of what? _________________

Medication use □ ***Check if none***	Dose	How many times a day

Surgeries: □No, □Yes: list ____

Allergies to medication: □No, □Yes ____

Family history: Father: □**Alive** □ heart disease, □ cancer of what?_______________ □none of these

Mother: □**Alive** □ heart disease, □ cancer of what?______________, □none of these

Do you smoke? □ Yes, how much?__________// □ used to, quit in ______// □ No (never)

Do you use alcohol? □ daily, □ less than daily (occasionally), □ not at all

Date of last physical___________________

Reason for today's visit-____