

# DEAN C. KRAMER, M.D.

1155 N.W. 64<sup>TH</sup> TERRACE  
GAINESVILLE, FL 32605  
352-331-6736

The following questions are designed to obtain some general information about your health history. Please complete the FRONT and the BACK of ALL pages.

Your appointment has been scheduled for \_\_\_\_\_ at \_\_\_\_\_ a.m./p.m.  
Please complete this form and bring it with you.

Please plan to arrive **at least 15 minutes** before your appointment so that you may register and have your office records prepared.

## **PATIENT INFORMATION (Please print or type)**

Name: \_\_\_\_\_ Sex: [  ] Male [  ] Female

Street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Person to notify in case of emergency: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Relationship: \_\_\_\_\_

Person responsible for payment of your professional fees: [  ] Myself [  ] Other

Other person responsible: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Relationship: \_\_\_\_\_

Referred by: \_\_\_\_\_

**INSURANCE INFORMATION**

Is your illness covered by Workers' Compensation Insurance? [ ] YES [ ] NO

If you have insurance coverage, please indicate the type(s):

[ ] Medicare [ ] Medicare Number: \_\_\_\_\_

[ ] Blue Cross/Blue Shield [ ] Contract Number: \_\_\_\_\_

[ ] Other insurance coverage: (list name of carrier and contract numbers here)

\_\_\_\_\_  
\_\_\_\_\_

**DESCRIBE THE MEDICAL PROBLEM(S) YOU HAVE COME TO DISCUSS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PREVIOUS SURGERY:** (Place a mark in the box next to the type of surgery you have had and the approximate date of the surgery)

[ ] Appendix	[ ] Hernia
[ ] Colon surgery	[ ] Hemorrhoids
[ ] Cardiac pacemaker	[ ] Hysterectomy
[ ] Gastric bypass	[ ] Stomach ulcer
[ ] Gallbladder	[ ] Colonoscopy
[ ] Heart stent placement	[ ] Upper endoscopy
[ ] Open heart surgery	[ ] Other:

## **PREVIOUS MEDICAL PROBLEMS:**

Please place a mark in the box next to the illness or illnesses that you currently have or have had in the past.

<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Ulcerative colitis	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Rheumatoid arthritis
<input type="checkbox"/> Uterine cancer	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Esophageal reflux	<input type="checkbox"/> Irritable bowel syndrome	<input type="checkbox"/> Anemia
<input type="checkbox"/> Helicobacter pylori infection	<input type="checkbox"/> Chronic diarrhea	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Duodenal ulcer	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Ovarian cancer
<input type="checkbox"/> Colon polyp(s)	<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Radiation therapy
<input type="checkbox"/> Esophageal varices	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Sleep apnea <input type="checkbox"/> CPAP
<input type="checkbox"/> Heart attack	<input type="checkbox"/> Stroke	<input type="checkbox"/> Abnormal heart rhythm
<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Seizures	

## **ALCOHOL AND TOBACCO**

Do you drink alcohol?      [ ] YES      [ ] NO

If "YES", how much alcohol do you drink in a week?

\_\_\_\_\_ cans of beer per week      \_\_\_\_\_ glasses of wine per week      \_\_\_\_\_ ounces of liquor per week

Do you use tobacco products?      [ ] YES      [ ] NO

## **FAMILY HISTORY**

Is your mother living? [ ] Yes      [ ] No (cause of death): \_\_\_\_\_

Is your father living? [ ] Yes      [ ] No (cause of death): \_\_\_\_\_

Have any immediate family members (mother, father, brother, sister, child) had any of the below conditions?

- |                                |                        |                  |
|--------------------------------|------------------------|------------------|
| [ ] Breast cancer              | [ ] Ulcerative colitis | [ ] Colon cancer |
| [ ] Heart attack before age 50 | [ ] Colon polyps       | [ ] Hypertension |
| [ ] Crohn's disease            | [ ] Ovarian cancer     | [ ] Diabetes     |

## **ALLERGIES**

List any drug allergies that you have: \_\_\_\_\_

Place an "X" in the box if you are allergic to any of the following:

- [ ] Eggs      [ ] Latex      [ ] Penicillin      [ ] Soy      [ ] Tape

## REVIEW OF SYMPTOMS

(CHECK ALL THAT APPLY)

<b>GENERAL</b>	<b>HEART AND BLOOD VESSELS</b>	<b>GI (CONTINUED)</b>
<input type="checkbox"/> CHILLS	<input type="checkbox"/> CHEST PAIN ON EXERTION	<input type="checkbox"/> EXCESS GAS
<input type="checkbox"/> FATIGUE	<input type="checkbox"/> PALPITATIONS	<input type="checkbox"/> HEARTBURN
<input type="checkbox"/> FEVER	<input type="checkbox"/> SHORTNESS OF BREATH	<input type="checkbox"/> LOSS OF BOWEL CONTROL
<input type="checkbox"/> LOSS OF APPETITE	<input type="checkbox"/> SWELLING IN FEET OR ANKLES	
<input type="checkbox"/> WEIGHT GAIN _____ POUNDS		<b>URINARY TRACT</b>
<input type="checkbox"/> WEIGHT LOSS _____ POUNDS		<input type="checkbox"/> BLOOD IN URINE
	<b>RESPIRATORY</b>	<input type="checkbox"/> FREQUENT URINATION
	<input type="checkbox"/> BREATHLESS WITH EXERTION	<input type="checkbox"/> KIDNEY STONES
<b>SKIN</b>	<input type="checkbox"/> COUGHING UP BLOOD	<input type="checkbox"/> LOSS OF CONTROL OF URINE
<input type="checkbox"/> SKIN RASH	<input type="checkbox"/> SORE THROAT	<input type="checkbox"/> PAINFUL URINATION
<input type="checkbox"/> CHANGE IN SIZE OF MOLES	<input type="checkbox"/> SLEEP APNEA	<input type="checkbox"/> URINARY URGENCY
<input type="checkbox"/> CHANGE IN COLOR OF MOLES	<input type="checkbox"/> WHEEZING	
<input type="checkbox"/> CHANGE IN NUMBER OF MOLES		
<input type="checkbox"/> VISUAL DEFECTS	<b>GASTROINTESTINAL</b>	<b>NEUROLOGIC</b>
	<input type="checkbox"/> BLOATING AND DISTENTION	<input type="checkbox"/> STROKE
	<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> SEIZURES
<b>EYES</b>	<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> FAINTING SPELLS
<input type="checkbox"/> GLAUCOMA	<input type="checkbox"/> DIFFICULTY SWALLOWING	<input type="checkbox"/> LOCALIZED MUSCLE WEAKNESS
<input type="checkbox"/> PAINFUL RED EYE (S)	<input type="checkbox"/> EXCESS BELCHING	
	<input type="checkbox"/> HEMORRHOIDS	<b>MENTAL HEALTH</b>
<b>EARS, NOSE, THROAT</b>	<input type="checkbox"/> INDIGESTION	<input type="checkbox"/> LOSS ON INTEREST IN LIFE
<input type="checkbox"/> ENLARGED LYMPH NODES	<input type="checkbox"/> PASSING BLOOD IN THE STOOL	<input type="checkbox"/> FEELINGS OF HOPELESSNESS
<input type="checkbox"/> HEARING LOSS	<input type="checkbox"/> VOMITING	<input type="checkbox"/> CRYING SPELLS FOR NO REASON
<input type="checkbox"/> HOARSENESS	<input type="checkbox"/> VOMITING BLOOD	<input type="checkbox"/> TROUBLE SLEEPING
<input type="checkbox"/> NECK MASS	<input type="checkbox"/> NAUSEA	
<input type="checkbox"/> NOSE BLEEDS	<input type="checkbox"/> PAINFUL BOWEL MOVEMENT	
<input type="checkbox"/> SORE THROAT	<input type="checkbox"/> PAINFUL SWALLOWING	



# Welcome to My Practice...

## Appointments

Your first appointment with Dr. Kramer will consist of an interview, examination, and discussion about your diagnosis and treatment. You should allow at least 90 minutes for this first appointment. Follow up appointments will usually last approximately 20-40 minutes.

## Emergency Care

In the event of an emergency, you should call 911. If the issue is urgent, but not an emergency, and cannot wait until the next business day, you should call your primary care physician or go to an immediate care center or a local hospital emergency department. Dr. Kramer does not provide emergency department care or inpatient hospitalization services. If you are hospitalized, Dr. Kramer will arrange any follow up GI care in his office after you are discharged from the hospital.

## Prescription Renewals

All prescriptions and authorizations for renewals should be requested during office hours. Refills and authorizations for renewals are typically handled within 24 hours.

**\*\* PLEASE NOTE: All prescription renewals require that you have been seen by Dr. Kramer within the last 12 months. If it has been a year or longer since you were last seen, an office appointment will be required before a prescription will be refilled.**

## Telephone Calls

You are encouraged to call the office with any questions that you have about your medical care. These questions will be answered by either Dr. Kramer or his staff during the scheduled time to return calls.

## Fees and Payments

Our goal is to provide you with high quality medical care at an affordable price. We feel, however, that it is your duty to know the limits and coverage of your particular insurance policy. Since we accept many insurance plans, we cannot know the specific guidelines of every patient's policy. You are expected to pay your portion of copayments and deductibles at the time of service.

*For patients with secondary insurance coverage, we will bill your secondary insurance company one time as a courtesy. If no payment is received, you will be responsible for payment.*

## Cancellation Policy

We strive to render excellent GI care to you and the rest of our patients. When an appointment is scheduled, that time is set aside for you, and when it is missed, that time cannot be used to treat another patient. In an attempt to be consistent with this, we have a cancellation policy as follows:

If you are unable to keep your appointment, you must call our office **at least 24 hours prior** to your scheduled appointment. For example, if you are scheduled for Thursday at 9 a.m., you should call us before 9 a.m. on Wednesday. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. **A fee of \$75.00 will be charged to you.** This fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

Additionally, if you are more than 20 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the \$75.00 cancellation fee will be charged.

Your timely cancellation allows us to make your scheduled time available for others waiting to be seen.

# **DEAN C. KRAMER, M.D.**

INTERNAL MEDICINE • GASTROENTEROLOGY



## **EDUCATIONAL BACKGROUND**

Yale University (undergraduate)

Washington University (St. Louis) (Doctor of Jurisprudence – J.D.)

University of Missouri (Doctor of Medicine – M.D.)

Internship, General Internal Medicine, Shands Teaching Hospital, Gainesville, FL

Residency, General Internal Medicine, Shands Teaching Hospital, Gainesville, FL

Fellowship, Gastroenterology, Shands Teaching Hospital, Gainesville, FL

## **ACADEMIC APPOINTMENTS**

Courtesy, Clinical Associate Professor of Internal Medicine,

Shands Teaching Hospital, Gainesville, FL

## **BOARD CERTIFICATION**

Diplomate, American Board of Internal Medicine

Diplomate, American Board of Gastroenterology

## **DEAN C. KRAMER, M.D.**

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### **DIRECTIONS TO DR. KRAMER'S OFFICE FROM I-75**

1. If you are traveling north or south on I-75, take the **Newberry Road exit 387** and head east toward downtown Gainesville.
2. Drive east on Newberry Road. Turn left at the traffic light onto **N.W. 66<sup>th</sup> Street** (entrance to North Florida Regional Medical Center). The Oaks Mall is directly across the street from the North Florida Regional Medical Center.
3. Proceed north on **N.W. 66<sup>th</sup> Street**. You will pass the hospital Emergency Department on the right (east side) and a three story parking garage on the left (west side) of the street.
4. Continue straight going north on **N.W. 66<sup>th</sup> Street**. The road will curve east (to the right) about 300 feet beyond the Emergency Department.
5. Follow **N.W. 66<sup>th</sup> Street** around the curve to **N.W. 64<sup>th</sup> Terrace** which will be on your left side.
6. Turn left onto **N.W. 64<sup>th</sup> Terrace**, heading north.
7. Go 500 feet to the third driveway on your right and turn into the **Physicians Park**.
8. Drive to the **STOP** sign. Dr. Kramer's office is the red brick building on your left.
9. If you need further directions, call the office **(352-331-6736)**.

### **DIRECTIONS TO DR. KRAMER'S OFFICE FROM DOWNTOWN GAINESVILLE**

1. Drive west on University Avenue--which turns into Newberry Road at 34<sup>th</sup> Street--toward I-75.
2. Turn right at the traffic light at **NW. 66<sup>th</sup> Street** (entrance to North Florida Regional Medical Center). The Oaks Mall will be directly across the street from the Medical Center on the south side of the street.
3. Proceed north on **N.W. 66<sup>th</sup> Street**. You will pass the hospital Emergency Department on the right (east side) and a three story parking garage on the left (west side) of the street.
4. Continue straight going north on **N.W. 66<sup>th</sup> Street**. The road will curve east (to the right) about 300 feet beyond the Emergency Department.
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