DEAN C. KRAMER, M.D.

1155 N.W. 64TH TERRACE
GAINESVILLE, FL 32605
352-331-6736
FAX: 352-331-0413
Website: Kramermedicalclinic.com

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.

PATIENT INFORMATION (Please print or type)

Name: ____Sex: [ ] Male [ ] Female

Street address: ____

City: __________________________________State: ______________Zip: ________________

Last 4 digits of SS #:___________________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: ____

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 YOUR DIGESTIVE TRACT PROBLEM(S)

____

____

____

____

____

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

[ ] Appendectomy	[ ] Hernia repair
[ ] Colon surgery	[ ] Hemorrhoids
[ ] Cardiac pacemaker	[ ] Hysterectomy
[ ] Gastric bypass	[ ] Stomach surgery
[ ] Gallbladder removal	[ ] Colonoscopy
[ ] Heart stent placement	[ ] Upper endoscopy
[ ] Sinus surgery	[ ] Nose surgery

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.

☐ Crohn's Disease	☐ Heart murmur	☐ Rheumatic fever
☐ Ulcerative colitis	☐ High cholesterol	☐ Rheumatoid arthritis
☐ Uterine cancer	☐ High blood pressure	☐ Hemorrhoids
☐ GERD	☐ Irritable bowel syndrome	☐ Anemia
☐ Diabetes	☐ Chronic diarrhea	☐ Emphysema
☐ Duodenal ulcer	☐ Gallstones	☐ Chronic fatigue
☐ Colon polyp(s)	☐ Pancreatitis	☐ Radiation therapy
☐ Hemorrhoids	☐ Diverticulitis	☐ Thyroid disease
☐ Fibromyalgia	☐ Kidney stones	☐ Migraine headaches
☐ Periodontitis	☐ COVID Infection	☐ Glaucoma
☐ Heart attack	☐ Stroke	☐ Abnormal heart rhythm

FAMILY HISTORY

- Is your mother living? [ ] Yes [ ] No (cause of death): ____
- Is your father living? [ ] Yes [ ] No (cause of death): ____
- Have any of your relatives been diagnosed with cancer before the age of 50?
  [ ] Yes [ ] No [ ] Adopted [ ] Don't Know
- Have any immediate family members (mother, father, brother, sister, child) had any of the below conditions listed below regardless of age?

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

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
- If "Yes", what kind? [ ] Cigarettes _________packs/day [ ] Snuff
  [ ] Chewing tobacco [ ] Pipe [ ] Cigars [ ] Vape

BOWEL MOVEMENTS:

- How many bowel movements do you usually have each day? __________________
- Have you had any recent change in the frequency of your bowel movements?
  [ ] Yes [ ] No
- Have you recently been experiencing constipation? [ ] Yes [ ] No
- Have you recently been having diarrhea? [ ] Yes [ ] No
- Have you been experiencing more than three bowel movements a day?
  [ ] Yes [ ] No
- Have you had any loss of control of your bowel movements recently?
  [ ] Yes [ ] No
- Have you seen any blood appear in or on the stool or on the toilet tissue or in the toilet water in the last month? [ ] Yes [ ] No
- Do you have abdominal cramping associated with your bowel movements?
  [ ] Yes [ ] No
- Does the need to have a bowel movement cause you to awaken from sleep?
  [ ] Yes [ ] No

HEIGHT AND WEIGHT

- How tall are you? ______________________
- What is the most that you have weighed in the last 12 months? ________________
- What is the least that you have weighed in the last 12 months? ________________
- What is your current weight? _________________

WATER SUPPLY

- Is your residence supplied by city water or well water?
  [ ] city water [ ] well water
- If your water supply comes from a well, have you had the water tested for contamination by your county health department in the last 12 months?
  [ ] Yes [ ] No

NON-PRESCRIPTION MEDICATIONS

Do you take any of the following non-prescription items? Check those that apply.

[ ] Vitamin D
[ ] Probiotics
[ ] B12
[ ] Aspirin
[ ] Acid reducing medications
[ ] Daily multivitamin
[ ] Other over-the-counter supplements
[ ] Non prescription pain medications
(Examples, Advil®, Ibuprofen, Aleve®, Motrin®, Bufferin®, Excedrin®)

OTHER DRUGS

In the last 12 monrha have you used any of the following recreational drugs?

[ ] Marijuana
[ ] LSD
[ ] Cocaine
[ ] Methamphetamines
[ ] Methadone
[ ] Opioids

SLEEP HABITS

- What time do you usually go to sleep? _________________________________
- Do you have difficulty falling asleep? [ ] Yes [ ] No
- Do you take any sleep aid medications? [ ] Yes [ ] No
- What time do you usually awaken from sleep for the day? __________________
- Do you have sleep apnea? [ ] Yes [ ] No
  If yes, do you use a CPAP breathing assist machine? [ ] Yes [ ] No
- How many times do you usually arise from sleep to urinate?
  [ ] None [ ] 1-2 [ ] 3-5 [ ] more than 5

BEVERAGES CONSUMED

- Do you drink coffee? If so, how many cups per day?
  [ ] None [ ] 1-3 [ ] more than 3
- Do you drink black tea? If so, how many cups a day?
  [ ] None [ ] 1-3 [ ] more than 3
- Do you drink green tea? If so, how many cups a day?
- Do you drink herbal teas? If so, how many cups a day?
- Do you drink sodas? If so, how many soda drinks per day? Examples: Coca Cola®, Pepsi Cola®, RC Cola® Sprite®, 7 UP®, Ginger Ale®.
  [ ] None [ ] 1-3 [ ] 4-6 [ ] More than 6
- Do you drink carbonated beverages other than sodas? If so, how many per day? Examples: Seltzer water, LaCroix®, Pellegrino®, Perrier®
  [ ] None [ ] 1-3 [ ] 4-6 [ ] More than 6
- Do you drink energy drinks more than twice a week such as Monster®, Red Bull®, Rockstar®, Jolt®? [ ] Yes [ ] No
- Do you drink any beverages that contain artificial sweeteners? [ ] Yes [ ] No
- Do you regularly use artificial sweeteners in or on your food? [ ] Yes [ ] No

DIAGNOSTIC STUDIES

- Have you had any of the following imaging studies done in the last 12 months? Check those that apply:
  - [ ] CT scan
  - [ ] MRI scan
  - [ ] Gallbladder sonogram
  - [ ] Bone density study
  - [ ] Upper endoscopy
  - [ ] Colonoscopy

ALLERGIES

- Do you have any drug allergies? [ ] Yes [ ] No If so, please specify
  ____
- Do you have any food allergies? [ ] Yes [ ] No If so, please specify
  ____

ALLERGY DIAGNOSIS AND TREATMENT

- Have you ever been diagnosed with hay fever? [ ] Yes [ ] No
- Have you ever been diagnosed with asthma? [ ] Yes [ ] No
- Do you use any nasal or oral inhalers? [ ] Yes [ ] No

NOSE ISSUES

- Have you ever been diagnosed with nasal polyps? [ ] Yes [ ] No
- Have you had multiple infections of the nose? [ ] Yes [ ] No
- Have you ever had recurrent sinus infections? [ ] Yes [ ] No

INTESTINAL SYMPTOMS

In the last month, have you had any of the following symptoms? Check those that apply:

[ ] Nausea
[ ] Vomiting
[ ] Heartburn
[ ] Loss of appetite
[ ] Night sweats
[ ] Involuntary weight loss of more than 5 pounds
[ ] Difficulty swallowing
[ ] Abdominal bloating and distention

DENTAL HISTORY

- Since you were born, how many dental cavities have been filled?
  [ ] None [ ] 1-5 [ ] 6-10 [ ] More than 10
- How frequently do you go to the dentist? [ ] Less than once a year
  [ ] Once a year [ ] Twice a year [ ] More than twice a year
- How frequently do you have your teeth cleaned by the dental hygienist?
  [ ] Less than once a year [ ] Once a year [ ] Twice a year
  [ ] More than twice a year
- Do you use an electronic rechargeable toothbrush? [ ] Yes [ ] No
- Do you use a standard bristle toothbrush? [ ] Yes [ ] No
- Do you use a Waterpik® to clean your teeth? [ ] Yes [ ] No
- Do you floss your teeth or use Gum Picks® after meals? [ ] Yes [ ] No
- Do you use a fluoride containing toothpaste? [ ] Yes [ ] No
- What is the name of your toothpaste?_________________________________
- Have you recently had red, swollen or bleeding gums? [ ] Yes [ ] No
- Have you ever been under the care of a periodontist (gum specialist)?
  [ ] Yes [ ] No
- Do you frequently have mouth sores (fever blisters)? [ ] Yes [ ] No
- Do you have sore gums? [ ] Yes [ ] No
- Are your teeth sensitive to hot and/or cold temperatures? [ ] Yes [ ] No
- Do you frequently experience burning tongue, mouth, or lips? [ ] Yes [ ] No
- Do you frequently have blisters in your mouth or on your lips? [ ] Yes [ ] No
- Have you ever had placement of any dental caps/crowns on your teeth?
  [ ] Yes [ ] No If so, how many? [ ] 1-2 [ ] 3-5 [ ] 6 or more
- Do you have any loose teeth? [ ] Yes [ ] No
- Do you wear dentures? [ ] Yes [ ] No
- Do you have any dental bridges? [ ] Yes [ ] No
- Have you noted a change in your bite or tooth position? [ ] Yes [ ] No
- Do you frequently suffer from dry mouth? [ ] Yes [ ] No

- Name of your dentist:____
  Address:____
  Telephone Number:____

- How long do you take to brush your teeth? Check one that applies.

  [ ] Unknown
  [ ] Less than 30 seconds
  [ ] Greater than 30 seconds but less than one minute
  [ ] More than one minute but less than two minutes
  [ ] Two minutes or longer
- Do you have any dental implants? [ ]Yes [ ] No
  If so, how many? [ ] 1-2 [ ] 3-5 [ ] 6 or more
- Have you had any root canals? [ ] Yes [ ] No
  If so, how many? [ ] 1-2 [ ] 3-5 [ ] 6 or more
- Have you had any teeth extracted other than wisdom teeth? [ ] Yes [ ] No
  If so, how many? [ ] 1-2 [ ] 3-5 [ ] 6 or more
- Have you ever received any radiation therapy treatments to you lips, tongue, thyroid gland, neck, parotid gland, or thymus? [ ] Yes [ ] No

ANTIBIOTIC USAGE

How many times in the last five years do you think that you have been prescribed antibiotics?
[ ] None [ ] 1-5 times [ ] 6-12 times [ ] More than 12 times
Have you ever used antibiotics for more than 10 days in a row at any time in your life?
[ ] Yes [ ] No

FORMATIVE YEARS OF LIFE

- Were you born by vaginal childbirth or Cesarean section?
  [ ] Vaginal birth [ ] Cesarean section [ ] Adopted [ ] Unknown
- Were you born full term or premature? [ ] Full term [ ] Premature
  [ ] Unknown
- Were you bottle fed or breast fed? [ ] Bottle fed [ ] Breast fed
  [ ] Unknown
- Were you considered a “colicky” infant? [ ] Yes [ ] No [ ] Unknown
- Did you experience multiple infections during the first 3 years of your life such as ear infections, tonsillitis, bronchitis etc.? [ ] Yes [ ] No [ ] Unknown
- Were you hospitalized for any illness during the first 3 years of your life?
  [ ] Yes [ ] No [ ] Unknown Type: ________________________________
- Did you lose time from attending school for any illnesses for more than 2-3 days when growing up? [ ] Yes [ ] No [ ] Unknown
- Were you ever treated with antibiotics for acne for more than a month?
  [ ] Yes [ ] No [ ] Unknown

COVID

- Have you had COVID infection? [ ] Yes [ ] No
- Have you received COVID vaccine? [ ] Yes [ ] No

FOREIGN BODY APPLICATIONS (BODY JEWELRY)

Have you had insertion of any of the following? (Check all that apply)

[ ] Eyebrow rings
[ ] Earrings
[ ] Nose ring
[ ] Lip ring
[ ] Tongue ring
[ ] Nipple rings
[ ] Belly button ring

PERFORATIONS, PENETRATIONS, AND IMPLANTS

(Check all that apply to you)

[ ] Breast implants
[ ] Cardiac pacemakers
[ ] Cataract implants
[ ] Cochlea ear implants
[ ] Collagen cosmetic injections
[ ] Cornea transplants
[ ] Coronary artery stents
[ ] Dental implants
[ ] Hip replacements
[ ] Intrauterine Devices
[ ] Tattoos
[ ] Bone screws, rods, pins for fractures
[ ] Heart valves
[ ] Insulin pumps
[ ] Knee replacements
[ ] Nerve stimulators
[ ] Pain control pumps
[ ] Port-A-Cath infusion pumps
[ ] Shoulder replacements
[ ] Spine surgery hardware
[ ] Surgical hernia mesh
[ ] Urinary catheters

HYGIENE AND COSMETICS

- Do your shower or take baths? (Check one) [ ] Shower [ ] Baths
- Do you use under arm deodorants? [ ] Yes [ ] No
- Do you apply perfumes, colognes, body sprays or washes? [ ] Yes [ ] No
- Do you apply artificial eye lashes? [ ] Yes [ ] No
- Do you use mascara? [ ] Yes [ ] No
- Do you use eye shadow? [ ] Yes [ ] No
- Do you use eye glitter? [ ] Yes [ ] No

MENTAL HEALTH

- Have you ever been diagnosed with anxiety? [ ] Yes [ ] No
- Have you ever been diagnosed with depression? [ ] Yes [ ] No
- Do you current see a mental health advisor? [ ] Yes [ ] No
- Have you ever been diagnosed with Attention Deficit Disorder? [ ] Yes [ ] No
- Have you ever been diagnosed with an eating disorder? [ ] Yes [ ] No

MEDICATION LIST

(PLEASE LIST *ALL MEDICATIONS* THAT YOU TAKE INCLUDING PRESCRIPTION MEDICATIONS, AS WELL AS VITAMINS, MINERALS, PAIN RELIEVERS, SUPPLEMENTS, PREBIOTICS, PROBIOTICS, ETC.)

MEDICATION	STRENGTH	# OF TIMES TAKEN DAILY
Example: Vitamin D	*1000 I.U.*	*Once*
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
21.		
22.		
23.		
24.		
25.		

EXERCISE FREQUENCY AND INTENSITY

- Do you exercise for 20-60 minutes three times a week or more?

  [ ] Yes [ ] No

- How would you grade your level of exercise intensity based on the examples given below?

  [ ] Low Intensity [ ] Moderate Intensity [ ] Vigorous Intensity

Low Intensity Activities
Sleeping
Watching television
Writing, desk work, typing, playing computer games, playing cards
Walking, less that 3.0 mph speed, level ground, strolling, slow
Moderate Intensity Activities
Bicycling, stationary bike, very light effort
Calisthenics, home exercise, light or moderate effort
Walking over 3.0 mph speed
Bicycling, <10 mph, leisure, to work or for pleasure
Vigorous Intensity Activities
Jogging
Calisthenics (e.g. pushups, situps, pullups, jumping jacks), heavy, vigorous effort
Weight lifting
Running in place (treadmill)