

Crockett Medical Clinic, INC
Patient History

Patient Name: _____ DOB _____ Male Female

Marital Status: Married Single Widowed Divorced

Employed Unemployed Occupation/Employer: _____

ALLERGIES: _____

Personal Medical History Please circle any that apply

High Blood Pressure Diabetes High Cholesterol Heart Disease
Hypothyroidism Hyperthyroidism Kidney Disease Stroke COPD/Asthma

Cancer-type: _____ Other: _____

Other Providers you see: _____

Surgeries:	Type	Date/Year

Family History: Circle Family Member

Hypertension: Mother Father Brother Sister

Diabetes: Mother Father Brother Sister

Heart Disease Mother Father Brother Sister

Cancer Mother Father Brother Sister

Tobacco: Current Past Never Cigarettes Smokeless Tobacco Dip

Amount per day: _____

Alcohol: Rare Occasional Social Never Alcoholism: Current History of

Drug Abuse: Never Current History of

Comments you would like for us to know about you: _____