Crockett Medical Clinic, INC
Patient History

Patient Name:___________________________________ DOB _______________ Male Female

Marital Status: Married Single Widowed Divorced

Employed Unemployed Occupation/Employer: ____

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: ____

ALLERGIES: ____

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

Personal History:

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: _____________________________________