GROFOOT M.D. P.A.

Patient Name: _____ **Nickname:** _____ **DOB:** _____

What is the name of current or previous medical provider? _____

When did you last see him/ her? _____

Current Medication(s):

Do you currently take any prescription drugs or over-the-counter medications/ vitamins or supplements?

Drug Name:	Strenght:	Frequency:	Taking for:	Prescribing Physician:
i.e. Lexapro	*10 mg tablet*	*1 daily*	*Anxiety*	*Dr. Example*

Medical History/ Condition(s):

Have you ever been told by a medical provider that you have or have had any of the following medical conditions?

Medical Condition(s):	Since and/ or when:
i.e. Anxiety	*1991*
☐ High Blood Pressure	
☐ High Cholesterol	
☐ Low Testosterone	
☐ Depression	
☐ Anxiety	
☐ Neuropathy (Nerve Pain)	
☐ Heart Disease	
☐ Heartburn (reflux)	
☐ Asthma	
☐ Cancer	
☐ Diabetes	

Medical Condition(s):	Since and/ or when:
☐ Seasonal Allergies	
☐ Liver Problems	
☐ Chickenpox as child	
☐ HIV	
☐ Genital Herpes	
☐ Genital Warts	
☐ Syphilis	
☐ Chlamydia	
☐ Gonorrhea	
☐ Hepatitis A	
☐ Hepatitis B	
☐ Hepatitis C	

Allergies/Intolerance: ☐ **YES** ☐ **NO**

Detail _____

GROFOOT M.D. P.A.

Surgical History:

Procedure(s)/ Surgery	Year of Procedure
i.e. Appendectomy	*2001*

Procedure(s)/ Surgery	Year of Procedure

Hospitalization(s):

Procedure(s)/ Surgery	Hospital Year/ Day(s) of Stay
i.e. Appendectomy Hospitalization	*2001 - 2 Days*

Procedure(s)/ Surgery	Hospital Year/ Day(s) of Stay

Family History:	Alive	Deceased	Medical Conditions	age at death
i.e. Cousin	X		Depression, Diabetes, Cancer: Oral	
Father:	☐	☐		
Mother:	☐	☐		
Paternal Grand Father:	☐	☐		
Paternal Grand Mother:	☐	☐		
Maternal Grand Father:	☐	☐		
Maternal Grand Mother:	☐	☐		

Do you have any siblings? ☐ **YES** ☐ **NO** # of brothers: _____ # of sisters: _____

Do they have any illnesses? ☐ **YES** ☐ **NO**

Sibling # 1: ☐ bro / ☐ sis Illnesses? _____

Sibling # 1: ☐ bro / ☐ sis Illnesses? _____

Sibling # 1: ☐ bro / ☐ sis Illnesses? _____

Children: ☐ boy / ☐ girl Age / Illnesses? _____

Children: ☐ boy / ☐ girl Age / Illnesses? _____

Children: ☐ boy / ☐ girl Age / Illnesses? _____

CROFOOT M.D. P.A.

Social History:

Do you smoke cigarettes? ☐ YES ☐ NO How often? ☐ 1 pack/ day ☐ 3-5/day ☐ Socially

Do you use drugs? ☐ YES ☐ NO Which: ☐ Marijuana ☐ Heroine ☐ Cocaine ☐ Meth

Other Drugs? _____

Do you drink caffeine? ☐ YES ☐ NO Type: ☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drinks

Do you drink alchohol? ☐ YES ☐ NO Type: ☐ Beer ☐ Wine ☐ Liquor

How often? ☐ 1-2/ Day ☐ 3-5/ Day ☐ Socially

Do you exercise regularly? ☐ YES ☐ NO Type? Weights Cardio

Frequency? Daily 3-5/ Week 1-2/ Week

Significant other? ☐ YES ☐ NO ☐ Single ☐ Partnered ☐ Married (how long?) _____ yrs/mo

Currently sexually active? ☐ YES ☐ NO Partners: ☐ Male ☐ Female ☐ Both

Occupation: _____

Travel outside USA? ☐ YES ☐ NO Where? _____

ROS:

Circumcised ☐ YES ☐ NO Last HIV- Test: _____

STD History

Syphilis	☐ YES	☐ NO	What year?	
Chlamydia	☐ YES	☐ NO		
Gonorrhea	☐ YES	☐ NO		
Herpes Simplex Virus (HSV)	☐ YES	☐ NO		
Human papillomavirus (HPV)	☐ YES	☐ NO		

HIV *Only for HIV+ Patients*

Date of Diagnosis: _____ Last Blood Work: _____

Risk Factor: ☐ Male to Male Sexual Intercourse ☐ IV Drug Use ☐ Blood Transfusion ☐ Other

Highest T-Cells Count: _____ Highest Viral Load: _____

Lowest T-Cells Count: _____ Lowest Viral Load: _____

List Current Meds: _____ or ☐ n/a

List Previous Meds: _____ or ☐ n/a

If possible. please email forms to CONTACT@CROFOOTMD.COM before your appointment.