Patient Name: _____
Date of Birth: _____
Today's Date: _____/_____/ _____

MEDICAL and SOCIAL HISTORY FORM

MEDICAL HISTORY:

What medical conditions do you have? Select all that apply or write in, if not listed:

Diabetes ____ High blood pressure ____ Thyroid disorder ____ Heart disease ____ High cholesterol ___ Arthritis ____ Cancer ____ Kidney disease ____
Glaucoma ____ Asthma ____ Allergies ____ Migraine headache ____ Anemia ____ Bronchitis/emphysema ____ Obesity ____ Acid Reflux ____

Other: 1) _____ 2) _____ 3) _____

SURGICAL AND HOSPITALIZATION HISTORY: (Attach separate sheet of paper as necessary)

List all of the surgeries or hospitalizations (with cause) you have had in the past ten years?

_____ _____ _____

HEALTH MAINTENANCE:

Please list the date of your last screening test below and indicate if there were any abnormal results: Colonoscopy _____
Eye exam _____Cholesterol test _____ Prostate exam _____ Dental exam _____ Blood work _____
Women Only: Menstrual Cycle _____ Pap smear _____ Mammogram _____

Immunizations/vaccines: Please list the year of your last: Tetanus shot _____ Flu shot _____ Pneumovax (Pneumonia shot) _____ Hepatitis A _____
Hepatitis B _____ Chicken pox _____ Shingrix (Shingles shot) _____ TB skin test _____

Prescription and Over-the-Counter Medications and Supplements currently taking with dosages (Please use separate sheet if not enough room):

Medication	Dosage	Time(s) of day taken

Allergic reactions to medicine or food (please list the TYPE OF REACTION):

Medication/food allergy	Reaction

GraceCottage FAMILY HEALTH

Patient Name: _____
Date of Birth: _____
Today's Date: _____/_____/ _____

MEDICAL and SOCIAL HISTORY FORM

SOCIAL HISTORY: Please check all that apply. Information will be kept confidential:

☐ Alcohol use: How many? _____ Frequency: ☐ Rare/never ☐ Daily ☐ Weekly ☐ Monthly
☐ Tobacco use: ☐ Everyday ☐ Former ☐ Never smoked
☐ Substance abuse ☐ Current use ☐ Past History
☐ Home/Environment: How many in your household _____
☐ Nutrition Health: Do you have a special diet? _____
☐ Exercise: Type(s): _____ Frequency: _____
☐ Sexually active ☐ Yes ☐ No; Orientation: _____
☐ Legal blindness or uncorrected visual impairment. (Please list ophthalmologist/
☐ Hearing deficit ☐ Right ☐ Left; Do you wear hearing aid(s)? ☐ Yes ☐ No
☐ Speech deficit
☐ Recent Travel (in the past six month). If so, where? _____

Fall Risk Assessment:

1. Have you fallen in the past three (3) months?
   ☐ Yes ☐ No IF YES, PLEASE CONTINUE:
2. Do you have a secondary diagnosis?
   ☐ Yes ☐ No
3. Do you use an aid to walk?
   ☐ Furniture ☐ Crutches, cane or walker ☐ Wheelchair
   ☐ None ☐ Bedrest/Immobile
4. How is your gait?
   ☐ Normal ☐ Impaired ☐ Weak ☐ Immobile
5. What is your current mental status?
   ☐ Forgetful ☐ Oriented to own ability

Employment Status:

☐ Active Military ☐ Full-Time ☐ Part-Time ☐ Student
☐ Disabled ☐ Not Employed ☐ Self Employed ☐ Retired

Employer or Date of Disability/Retirement: _____

	TYPE OF PROVIDER	PROVIDER NAME	PROVIDER TELEPHONE NUMBER
Please list all providers who share in your medical care	Cardiology		
	ENT		
	Gastroenterology		
	GYN		
	Neurology		
	Ophthalmology/Optometry		
	Orthopedics		
	Psychology/Psychiatrist/Therapist		
	Pulmonology		
	Rheumatology		
	Urology		
	Other:		