Grace Cottage Family Health

Patient Name: ________________________________Gender Identity:___________ Birth Sex:_____________________

Date of Birth:__________________________________Pronouns:______________________Race: ____________________

Today's Date: _________________________________ Primary Language: _______________________________________

Medical and Social History Form

Medical History:

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

Diabetes	High blood pressure	High Cholesterol
History of Heart Attack or Stroke	Cancer	Depression or Anxiety
COPD or Asthma	Thyroid Disorder	Acid Reflux or GERD
Eye Disorders	Migraines	Chronic Pain

Name:______________________________

Surgeries and year:

Health Maintenance:

Please list the date of last screening exams if applicable and indicate if they were abnormal.

Colonoscopy:	Pap Smear:	Prostate Exam:
Mammogram:	Dental Exam:	Eye Exam:
Cholesterol screen:	Diabetes Screen:	Other:

Immunizations:

Tetanus/Tdap/Td:	Flu Shot:	Shingles:
HPV:	Hep B:	Hep A:
Chicken Pox:	Pneumonia:	Other:

Sexual Health:

Sexual Orientation:__________________________ Are you sexually active? yes/no Birth Control:_____________________

Social History:

Alcohol Use: How many? ______How Often? ________ Do you feel you have a problem with alcohol? yes/no

Tobacco Use: Smoke? yes/no. How long? _________ How much? _______ Vape? yes/no. Chewing tobacco? yes/no

Name:______________________________

Recreational Drug Use: Current Use? yes/no. Past History of Use? yes/no. Type?______________________________
How many people live in your house? __________Do you have adequate housing? yes/no
Nutrition: Do you have a special diet?______________________________Do you have access to healthy food? yes/no

Do you have vision impairment? Blind? yes/no. Glasses/Contacts? yes/no. Other?______________________________
Do you have a hearing impairment? yes/no Hearing aids?____________________Other?________________________
Have you had a fall recently? yes/no When?_______________________Do you use a cane or walker? yes/no

Highest level of education?_________________Military:______________________
Employment/Retired/Disabled? ___________________

Please List All Specialists Who Share Your Medical Care:

Specialty: (Example: cardiology)	Name of Provider: (Example: Dr Heart)	Phone Number and Location: (Example: 603-650-5000, Dartmouth)

Name: :______________________________

Please list all medications and supplements and over-the-counter medications you take:

Medication Name (Example: Metformin)	**Dosage** (Example: 500mg)	**How often you take it** (Example: 1 tab in am, 1 tab in pm)

Name:______________________________