

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: :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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)