Grace Cottage Family Health

Patient Name: _____Gender Identity:_____ Birth Sex:_____

Date of Birth:_____Pronouns:_____Race: _____

Today's Date: _____ Primary Language: _____

Gender Identity: Please check box below

☐ Identifies as male	☐Identifies as female	☐Female-to-Male (FTM)/Transgender Male/Trans Man	☐Male-to-Female (MTF)/Transgender Female/Trans Women
☐Genderqueer, neither exclusively male nor female	☐Choose not to disclose	☐ Additional gender category or other: Please specify →	_____

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 the 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:_____