GLACIER COMMUNITY HEALTH CENTER, INC.
PATIENT SOCIAL AND MEDICAL HISTORY

Your Name:_____ Gender: ___ Male ___ Female Date of Birth: _____

SOCIAL HISTORY:

Are you currently working? (list job title) _____ Education Completed: _____

Do you have children? Y N Ages? _____ # Living____ #Dead____

Do you use tobacco? Y N How much? _____ Do you drink alcohol? Y N How much?_____

What type? _____ How long? _____ How often?_____ What type?_____

Do you have any special religious beliefs which may affect your ability to receive health care? _____

If yes, please describe:_____

How do you prefer to learn: ☐ By seeing illustrations? ☐ By hearing? ☐ By reading? ☐ By a combination?

Do you have any problems with: Hearing – yes no If yes, describe_____

Vision -- yes no If yes, describe _____

HEALTH HISTORY:

Do you have any known **PHYSICAL LIMITATIONS**? (name them)_____

Causes of physical limitation_____ Work related injury? Y N

MEDICINES YOU ARE TAKING (list all prescribed and non-prescribed medications): _____

_____

ALLERGIES / INTOLERANCES:_____

SURGERIES (include date & physician)_____

ILLNESSES: Check where you or members of your family (parents, grandparents, siblings) have had the following illness or problems.

YOU	YOUR FAMILY	WHO		YOU	YOUR FAMILY	WHO	
____	_____	_____	Alcoholism	____	_____	_____	Hemorrhoids
____	_____	_____	Anemia	____	_____	_____	Hepatitis or Liver Disease
____	_____	_____	Arthritis	____	_____	_____	Hernia
____	_____	_____	Asthma	____	_____	_____	High Blood Pressure
____	_____	_____	Bleeding Disorder	____	_____	_____	Kidney/Bladder problems
____	_____	_____	Cancer, Tumor	____	_____	_____	Low Blood Pressure
____	_____	_____	Chronic Bowel disease	____	_____	_____	Nervous Breakdown/Mental Illness
____	_____	_____	Chronic Lung Disease	____	_____	_____	Peptic Ulcer Disease/Stomach Ulcer
____	_____	_____	Diabetes	____	_____	_____	Pneumonia / Bronchitis
____	_____	_____	Drug Abuse	____	_____	_____	Rheumatic Fever
____	_____	_____	Depression	____	_____	_____	Sleep Apnea
____	_____	_____	Eczema, Hives, Rashes	____	_____	_____	Stroke
____	_____	_____	Emphysema / COPD	____	_____	_____	Suicide Attempt
____	_____	_____	Epilepsy/Seizures	____	_____	_____	Thyroid Disease
____	_____	_____	Eye Problems / Glaucoma	____	_____	_____	Tuberculosis
____	_____	_____	GERD – Reflux Disease	____	_____	_____	Sexually Transmitted Disease
____	_____	_____	HIV/AIDS	____	_____	_____	Whooping Cough
____	_____	_____	Headaches	____	_____	_____	Croup, RSV, Influenza
____	_____	_____	Heart Attack	____	_____	_____	Menstrual Problems
____	_____	_____	Heart Failure			_____	Other Health Problems
____	_____	_____	Heart Arrhythmia				

List physician(s) who are involved in your health care:_____