Grand Primary Care

Courtney Smith PA-C

3550 Fairlanes Ave SW, Suite A
Grandville, MI 49418

P: (616) 333-5913
F: (833) 974-5242
admin@grandprimarycare.com

www.grandprimarycare.com

Demographics

Full name (and maiden name, if applicable) _____

Date of birth _____

Emergency contact (name, nature of relationship, phone number)

_____

Ethnicity:
- ○ Hispanic or Latino
- ○ Not Hispanic or Latino
- ○ Prefer not to answer

Race:
- ○ White
- ○ Black/African American
- ○ Native American
- ○ Asian
- ○ Pacific Islander
- ○ Other
- ○ Prefer not to answer

Primary spoken language _____

Marital status _____

Sexual orientation:
- ○ Heterosexual/straight
- ○ Homosexual
- ○ Bisexual
- ○ Other: _____
- ○ Prefer not to answer

Gender identity:
- ○ Female
- ○ Male
- ○ Non-binary
- ○ Prefer not to answer

Pronouns:
- ○ She/Her
- ○ He/Him
- ○ They/Them
- ○ Other: _____
- ○ Prefer not to answer

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Allergies (and reactions, for example, rash, hives, trouble breathing, etc.):

_____

_____

Current medical problems:

_____

_____

_____

Past medical problems:

_____

_____

_____

Please list your current medications with dose and frequency (prescriptions and over the counter):

_____

_____

_____

Please list any surgeries and the year the surgery was performed.

_____

_____

_____

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Family history:

✔ CHECK ALL THAT APPLY	Alcohol/Drug Abuse	Asthma	Cancer (type:_____)	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other:_____	Other:_____	Other:_____
Mother																		
Father																		
Brother																		
Sister																		
Child																		
MGM																		
MGF																		
PGM																		
PGF																		
Other:_____																		

Social History:

	Yes	No
Have there been any recent changes to your family/social situation?		
Do you have smoke detectors and carbon monoxide detectors at home?		
Are there any smokers in your home?		
Are there guns present in your home?		
If so, are the guns locked away?		
Do you routinely wear your seatbelt (or use a carseat for young children)?		
Do you or have you ever smoked tobacco?		
Do you or have you ever vaped nicotine?		
Do you or have you ever used chewing tobacco?		
Do you consume alcohol?		
Do you use any recreational substances?		
Do you have an advanced directive or a medical power of attorney?		

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If you currently smoke/vape or have in the past, please list how much you smoke/smoked and for how long: _____

If you consume alcohol, how many days per week will you consume an alcoholic beverage? And how many drinks will you typically consume over the course of a day?

_____

What is the highest level of education that you've completed:

_____

Are you currently employed? If so, please list your employer and your role.

_____

Do you follow any specific diet? (for example, vegetarian, vegan, carnivore, gluten-free, standard American diet, etc.)

_____

How many days per week do you complete at least 30 minutes of aerobic exercise, such as going for a walk, jogging, riding a bike, or swimming: _____

How many days per week do you lift heavy weights: _____

Are you sexually active? YES / NO (circle one)

If yes, with male partners / female partners / both (circle one)

Are you using contraception (pregnancy prevention)? YES / NO (circle one)

If yes, which method(s) of contraception do you and your partner use? _____

_____

Do you feel safe in your relationship? YES / NO (circle one)

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Females only:

Age when you had your first menstrual period: _____

Date of your most recent menstrual period, if you are pre-menopausal: _____

If post-menopausal, at what age did you stop having menstrual cycles: _____

How many times have you been pregnant: _____

Number of full-term deliveries: _____

Number of pre-term deliveries: _____

Number of spontaneous miscarriages: _____

Number of induced miscarriages: _____

Number of ectopic pregnancies: _____

Number of living children: _____

Age when you delivered your first child: _____

How many first-degree relatives have or have had breast cancer (this includes only your biological mother, sisters, and daughters): _____

Have you ever had a breast biopsy? YES or NO