Grass Valley
Extended Care

136 Glasson Way - Grass Valley, California 95945
Office: 530-274-0200
www.grassvalleyextendedcare.com

Thank you for choosing Grass Valley Extended Care.
We look forward to being part of your healthcare team.

Name:	**Date of Birth:**
How did you hear about our practice?	
Phone:	Address:
Pharmacy:	Email:

What are your biggest health concerns?

Insurance	
Insurance Provider:	ID Number:
Name of Cardholder:	
Insurance Phone:	Insurance Address:

Please attach a copy of your current health insurance

Other Physicians and Specialists

Past Medical History

Condition/Disease	Year Began	Condition/Disease	Year Began
☐ Hypertension		☐ Others	
☐ High Cholesterol			
☐ Hypothyroidism			
☐ COPD, Emphysema or Asthma			
☐ Diabetes			
☐ GERD			
☐Depression/Anxiety			
☐Heart Problems			

Past Surgical Procedures/Hospitalizations/Surgeries

Operation/Hospitalization/ Injury	Month/Year	Operation/Hospitalization/ Injury	Month/Year

Medication or Food Allergies or Intolerances

Medication/Food	Reaction	Medication/Food	Reaction

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Disease Prevention and Health Maintenance
Please list below the most recent dates of your vaccines and health screening tests

	Month/ Year		Month/ Year		Month/ Year
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		Heart Catheterization	
Tetanus Vaccine		Colonoscopy		Endoscopy (EGD)	
Hepatitis B Vaccine		Bone Density		Heart Stress Test	
Shingles Vaccine		EKG		Ab Aneurysm Screen	
Gardasil Vaccine		Chest X-Ray		HIV Test	

Medications, Vitamins and Herbal Supplements

Medication	Strength	# of pills taken and frequency	Medication	Strength	# of pills taken and frequency
Example: Tylenol	500 mg	1/twice a day			

Social, Educational, Work History

Marital Status:	Age of children (if any)	Work Status (Circle one) Unemployed/Employed/Retired/Disabled
Highest level of education:	What are your hobbies?	
Do you drink alcohol?	Type of Alcohol?	# of drinks per week?
Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?	If so, what year did you quit?	# of years you smoked?
On average, how much did you smoke per day?	What types of exercises do you perform, duration and frequency:	
Do you drink plenty of water?	In what type of residence do you live (i.e. house, assisted living, nursing home?)	
Are you sexually active?	Do you have sex with: Men/ Women/Both	How many partners have you had during the past 12 months?
Are you concerned that you may have been exposed to HIV?		

Family Health History
Please list below, the health history of you blood (genetic) first degree relatives

Relative	Living or deceased	Current age or Age at death	Cause of death	Health Problems
Mother				
Father				
Brother(s)				
Sister(s)				

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Review of Systems

Please review the following symptoms and circle those items that are a problem for you

Vision problems	Wheezing	Lumps in breast	Frequent Urination	Excessive hunger
Hearing problems	Asthma/COPD	Breast discharge	Incontinence	Excessive thirst
Sinus problem	Emphysema	Trouble swallowing	Blood in urine	Weakness
Hay fever	Bronchitis	Nausea	History of STD's	Fatigue
Nosebleeds	TB exposure	Vomiting	Anemia	Fever/sweating
Sore throat	Chest pain	Abdominal pain	Easy bruising	Fainting
Hoarseness	Chest discomfort	Hepatitis/Jaundice	Pain in legs	Seizures/Tremor
Lumps in neck	Shortness of breath	Gallstones	Joint pain/stiffness	Headaches
Tooth problems	High blood pressure	Diarrhea	Blood clot	Numbness/Tingling
Cough	Diabetes	Constipation	Weight loss/gain	Anxiety/depression
Coughing blood	High cholesterol	Blood in stool	Heat/cold intolerance	Difficulty sleeping

☐ Place an X in the box, if you have none of the above

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Shingles Vaccine		EKG		Ab Aneurysm Screen	
Gardasil Vaccine		Chest X-Ray		HIV Test	

Tell us a fun fact about yourself!

Thank you for choosing us as your primary care provider and taking the time to fill out your paperwork. A team member will be calling you to discuss your health care needs. If you have any questions, please feel free to call us! 530-274-0200