Patients Name: _____

Adult Summary Form

Date of Birth: _____

Medical Record #: _____

Primary Care Provider: _____

Drug Allergies/Sensitivities: _____

Emergency Phone #: _____ Contact Person/Relationship: _____

ICD Code	Chronic Medical Problem List	Date	Past Surgical History	Date
			Hospitalizations	**Date**

Family History of

Y	N		Family Member
☐	☐	Alzheimer's Dz	_____
☐	☐	Breast Ca	_____
☐	☐	CAD	_____
☐	☐	Cerebrovas. Dz	_____
☐	☐	Cervical Cancer	_____
☐	☐	Colon CA	_____
☐	☐	Depression	_____
☐	☐	DM	_____
☐	☐	Fe Storage	_____
☐	☐	Glaucoma	_____
☐	☐	Hyperchol.	_____
☐	☐	HTN	_____
☐	☐	Ovarian CA	_____
☐	☐	Prostate CA	_____
☐	☐	Skin CA	_____
☐	☐	Thyroid Dz	_____

Initial Risk Assessment

	Date
☐ Alcohol/Drug Use	_____
☐ STDs	_____
☐ Domestic Violence	_____
☐ Depression	_____
☐ Osteoporosis	_____
☐ Geriatric Assessment	_____
☐ MMSE	_____
☐ _____	_____

Social History

☐ Married ☐ Single ☐ Civil Union

☐ Divorced ☐ Widow(er)

☐ Lives Alone ☐ Separated

Occupation: _____

Religious Preference: _____

Advance Directive? ☐ Yes ☐ No
If Yes, Date: _____

Educ.: ☐ JHS ☐ HS ☐ College

☐ Other _____

Signature: _____ Date: _____