Patients Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Adult Summary Form** Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Record #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Allergies/Sensitivities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Person/Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **ICD Code** | **Chronic Medical Problem List** | **Date** | **Past Surgical History** | **Date** |
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|  |  |  | **Hospitalizations** | **Date** |
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| **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, PHQ2 score: \_\_\_  🞏 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: \_\_\_\_