Patient’s 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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| **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 🞏 SeparatedOccupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Religious Preference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Advance Directive? 🞏 Yes 🞏 NoIf Yes, Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Educ.: 🞏 JHS 🞏 HS 🞏 College 🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_