Patients Name: _____

Adult Summary Form

Date of Birth: _____

Previous PCP: _____

Drug Allergies/Sensitivities: _____

ICD Code	Chronic Medical Problem List	Date	Past Surgical History	Date
			Hospitalizations	**Date**
	Last Colonoscopy			
	Females:			
	Last Mammogram			
	Last PAP smear			

Family History of

Y	N	Family Member
☐	☐	Alzheimer's _____
☐	☐	Cancer – type of _____
☐	☐	Coronary artery _____
☐	☐	Cerebrovas. Dz _____
☐	☐	Depression _____
☐	☐	Diabetes _____
☐	☐	Anemia _____
☐	☐	Glaucoma _____
☐	☐	High cholesterol _____
☐	☐	High Blood press _____
☐	☐	Thyroid _____

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

Do you have a Health Care Proxy: -
_____

Do you Smoke: ☐ Yes ☐ No
If so, for how many years? _____

Educ.: ☐ JHS ☐ HS ☐ College

Signature: _____ Date: _____