Adult Medical Summary   Patient Name: _____ Date of Birth_____

Past Medical History: (Please check all that apply)   **Today's date:** _____

◯ Anxiety Disorder	◯ Fibromyalgia	◯ Migraine Headaches
◯ Arthritis	◯ Gout	◯ MRSA Infections
◯ Asthma	◯ Has pacemaker	◯ Mumps
◯ Bleeding Disorder	◯ Heart Attack	◯ Osteoporosis
◯ Cancer	◯ Hepatitis	◯ Pneumonia
◯ Chicken Pox	◯ Hive or Eczema	◯ Seizure Disorder
◯ Depression	◯ Kidney Disease	◯ Scarlet Fever
◯ Diabetes- Insulin	◯ Kidney Stones	◯ Stroke
◯ Diabetes Non-Insulin	◯ Learning Disabilities	◯ Whooping Cough
◯ Difficulty in Urinating	◯ Liver Disease	◯ Other, Explain_____
◯ Diverticulitis	◯ Measles	_____

Drug Allergies: _____

Past Surgical / Hospital History:

Surgery/Hospitalizations	Reason	Year	Hospital
1.			
2.			
3.			
4.			
5.			

Family Health History:

Relation (please check across all that apply or indicate type)	Alive y/n	Age	Alcoholism	Anemia	Cancer/ type	Diabetes	Heart Disease	Hypertension	Kidney Disease	Liver Disease	Mental Disorder / type	stroke	Thyroid Disorder
Mother													
Father													
Brother/Sister 1.													
2.													
3.													
4.													
Grandfather (maternal)													
Grandmother (maternal)													
Grandfather (paternal)													
Grandmother (paternal)													

Social Information:

Alcohol Use	Yes/No	Details (how many, where, who)
Smoking Status		
Exercise		
Live with		
Personal Safety		
1. Have you been hit, punched , strangled or threatened to hurt you?		
2. Has anyone forced you to have sex?		
3. Are you afraid of your partner?		
4. Do you wear a seat belt?		
Do you wear or need glasses or contacts?		
Do you wear or need a hearing aid?		
Do you use Illicit Drugs?		
Do you use a cane, walker or wheelchair?		

11/2016   Patient Name: _____ Date of Birth_____