Adult Patient Summary

Name: _____ DOB: _____ Initial Date: _____ Annual Update: _____
Allergies (food, medication, other): Yes ☐ Explain _____ No ☐
BP: _____/_____ HR: _____ Weight: _____ Height: _____ BMI _____
Advance Directives: Yes ☐ No ☐ Refused ☐ If "Yes," is copy on file?: Yes ☐ No ☐
Advance Directives Counseling/Information Provided: Yes ☐ No ☐
Comments: _____

Medical History

Please check to indicate the following conditions:

Asthma		Hemophilia	
Cancer-type		Hepatitis	
Coronary Artery Disease		High Blood Pressure	
Convulsions/Seizures		Kidney Disease	
Depression		Sexually Transmitted Disease-type	
Diabetes		Stroke	
Emphysema		Tuberculosis	
Eye Problems		Thyroid Disease	
Heart Attack		Other, please explain	

Health Habits

Do you smoke or use any tobacco products? Yes ☐ No ☐ Quit ☐
Number of cigarettes each day? _____ For how many years? _____

Do you drink alcohol? Yes ☐ No ☐ Quit ☐
How much? _____ How often? _____

Have you regularly used other drugs? Yes ☐ No ☐
If yes, are you still using them? Yes ☐ No ☐

Family History

Please check all the diseases that a family relation has/had and not relation:

Disease	✓	Relation	Disease	✓	Relation
Alcoholism or Drug Use			Kidney Disease		
Cancer-type			Osteoporosis		
Depression			Mental Illness		
Diabetes			Stroke		
Heart Disease			Thyroid Disease		
High Blood Pressure			Other, please explain:		
High Cholesterol					

Note: A Body Mass Index Table is available online at http://www.nhlbi.nih.gov/guidelines/obesity/bmi_tbl.htm.