

# 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](http://www.nhlbi.nih.gov/guidelines/obesity/bmi_tbl.htm).