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Adult Summary

What brings you you to the office today?

How is your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any other conserns you would like to address?

Current Medications

What medication are you currently taking?

Name	Dosage	Frequency
Name	Dosage	Frequency
Name	Dosage	Frequency
Name	Dosage	Frequency
Name	Dosage	Frequency

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates (Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name	Reaction
Name	Reaction
Name	Reaction

Past Medical History

☐ Alcoholism ☐ Back Problems ☐ Ear Problems ☐ Hepatitis - A, B, or C ☐ Measles ☐ Skin Disorder
☐ Allergies ☐ Bleeding Disorder ☐ Eating Disorder ☐ High Blood Pressure ☐ Migraines ☐ Stomach Ulcer
☐ Anemia ☐ Blood Disease ☐ Epilepsy ☐ High Cholesterol ☐ Osteoporosis ☐ Substance Abuse
☐ Anxiety Disorder ☐ Blood Transfusion ☐ Glaucoma ☐ Joint Disorder Kidney ☐ Pneumonia ☐ Thyroid Disorder
☐ Arthritis ☐ Cancer ☐ Gout ☐ Disorder Liver ☐ Polio ☐ Tuberculosis
☐ Asthma ☐ Diabetes ☐ Heart Disease ☐ Disorder ☐ Rheumatic Fever ☐ Venereal Disease
☐ AIDS / HIV ☐ Depression ☐ Heart Problems ☐ Lung Disease ☐ Stroke

Hospitalizations & Surgeries

Reason	Date
Reason	Date
Reason	Date

Women Only:

of Pregnancies # of Miscarraiges # of Abortions Last # of Living

Pap Smear Last Mammogram Birth Control Method

Family History

Has anyone in your family ever had any of the following conditions?

☐ Alcoholism ☐ Cancer ☐ Joint Disorder Kidney
☐ Allergies ☐ Depression ☐ Disease Liver Disorder
☐ Alzheimer's ☐ Diabetes ☐ Lung Disease
☐ Anemia ☐ Epilepsy ☐ Migraines Psychiatric
☐ Anxiety ☐ Genetic Disorder ☐ Disorders
☐ Arthritis ☐ Glaucoma ☐ Osteoporosis Stroke
☐ Asthma ☐ Heart Disease ☐ Substance Abuse
☐ AIDS/HIV ☐ Hepatitis ☐ Thyroid Disorder
☐ Bleeding Disorder ☐ High Cholesterol ☐
☐ Blood Disorder ☐ High Blood Pressure ☐

Details:

Lifestyle Factors

Are you sexually active?

☐ Yes ☐ No # of partners in past year ____________

Do you wished to be checked for STDs?

☐ Yes ☐ No

Has anyone in your home ever physically or verbally hurt you?

☐ Yes ☐ No

Have you ever smoked?

☐ Yes ☐ No # of years ____________ # packs/day ____________

Do you smoke now?

☐ Yes ☐ No # packs/day ____________

Do you use recreational drugs?

☐ Yes ☐ No types? ____________ # times/week ____________

How much allcohol do you drink per week?

drinks/week ____________

How much coffeine do you drink per day?

drinks/day ____________

How often do you exercise?

times/week ____________