Patient Summary Form

Patient Name: _____

Date of Birth: _____

Previous Primary Care Provider: _____

Emergency Phone #: _____ Contact Person/Relationship: _____

Social History

Birthplace: _____

☐ Married ☐ Single ☐ Civil Union
☐ Divorced ☐ Widow(er)
☐ Lives Alone ☐ Separated

Education: ☐ Middle School Grade
☐ HS Grade
☐ College ☐ Some college ☐ Degree
Type of Degree _____

Occupation: _____

Religious Preference: _____

Advance Directive/Living Will?
☐ Yes ☐ No
If Yes, Date: _____

Please check the box if the following applies. If yes, please explain:

☐ STDs _____
Received treatment? Yes No

☐ Domestic Violence/
Physical Abuse _____

☐ Tobacco Use
Type _____
Packs per day _____ for _____ years
Date quit _____

☐ Marijuana Use
If yes, issued a medical card? Yes No

☐ Alcohol Use
Drinks _____ per day week month
How often do you have 6 or more drinks on 1 occasion? _____
If heavy use, how many years _____

☐ Illicit Drug Use
Type _____

Medical History

Check the box if you've ever had the following:

☐ Cancer Type _____
☐ Heart Attack
☐ Coronary Artery Disease
☐ Congestive Heart Failure
☐ High blood pressure
☐ High Cholesterol
☐ Rheumatic Fever
☐ Stroke
☐ Diabetes Type _____
☐ Gallstones
☐ Liver Disease
☐ Hepatitis Type _____
☐ Jaundice
☐ Ulcers
☐ Heartburn/Acid Reflux
☐ Frequent UTI's
☐ Enlarged Prostate
☐ Kidney Disease
☐ Kidney Stone
☐ Diverticulitis
☐ Crohn's Disease
☐ Ulcerative Colitis
☐ Irritable Bowel Syndrome
☐ Asthma
☐ COPD
☐ Emphysema
☐ Pneumonia
☐ Tuberculosis
☐ Positive TB skin test
☐ Osteoporosis
☐ Arthritis
☐ Gout
☐ Mononucleosis
☐ Polio
☐ Anemia
☐ Glaucoma
☐ Hyperthyroid
☐ Hypothyroid
☐ Hashimoto's
☐ Cystic fibrosis
☐ Lyme's Disease
☐ HIV
☐ Syphilis
☐ Herpes
☐ Gonorrhea
☐ Chlamydia
☐ Depression
☐ Migraines
☐ Seizures
☐ Epilepsy

☐ Other _____

Past Surgical History

If yes, check the box and state the year:

☐ Brain surgery
☐ Brain aneurysm repair
☐ Heart surgery
☐ Pacemaker/Defibrillator
☐ Vascular Surgery/Stent
☐ Lungs/Lobectomy
☐ Thyroid
☐ Appendix
☐ Gall Bladder
☐ Hernia
☐ Abdominal Aneurysm repair
☐ Gastric Bypass
☐ Shoulder
☐ Foot
☐ Hand
☐ Joint replacement
☐ Hip ☐ Right ☐ Left
☐ Knee ☐ Right ☐ Left
☐ Spinal
☐ Neck ☐ Back
☐ Amputation
☐ Uterus/Hysterectomy
☐ Ovaries
☐ Vasectomy
☐ Tubal Ligation
☐ Prostate Cancer surgery
☐ Breast Cancer surgery
☐ Other cancer related surgery
☐ Plastic surgery
☐ Other _____

Family History of

	Family Member(s)
☐ Alzheimer's Dz	
☐ Stroke/CVA	
☐ Cervical Cancer	
☐ Ovarian CA	
☐ Prostate CA	
☐ Skin CA	
☐ Breast Ca	
☐ Colon CA	
☐ Other Cancer	
☐ Anemia	
☐ Glaucoma	
☐ Diabetes	
☐ Obesity	
☐ CAD	
☐ Heart Attack	
☐ High Cholesterol	
☐ Hypertension	
☐ Hyperthyroid	
☐ Hypothyroid	
☐ Asthma	
☐ Kidney Disease	
☐ Heart Failure	
☐ Arthritis	
☐ Osteoporosis	
☐ Depression	
☐ Mental Illness	
☐ Migraines	
☐ Crohn's Disease	
☐ Ulcerative Colitis	
☐ Diverticulitis	
☐ Irritable bowel	

Other_____

Initial Risk Assessment/Preventative Care

Please check the box for the following:
If yes, please state the date when completed.

	DATE
☐ Pulmonary Function Test	
☐ Chest X-ray	
☐ Pneumococcal Vaccine	
☐ Depression screening	
☐ Mammogram	
☐ DEXA Scan	
☐ PAP exam	
☐ Colonoscopy	
☐ Fecal Occult Blood Test (Colon cancer screening)	

Gynecological/Obstetrical History:

Name of OB/GYN:_____

Age when you started Menstruating:_____

Date of Last PAP: _____
History of abnormal PAP's ☐ Yes ☐ No
Breast Exam ☐ Yes ☐ No Date_____
Menstrual Cycles ☐ Regular ☐ Irregular
Abnormal bleeding ☐ Yes ☐ No
Painful periods ☐ Yes ☐ No

Use of Contraception ☐ Yes ☐ No
Type:_____
Number of Pregnancies:_____
Number of Births:_____
Vaginal Births:_____
C-Sections:_____
Terminations: ☐Yes ☐No Number_____
Age at Menopause:_____

IMMUNIZATIONS	Date

ALLERGIST	
CARDIOLOGY	
ENDOCRINOLOGY	
GASTROENTEROLOGY	
NEUROLOGY	
OBSTETRICS/GYNECOLOGY	
ONCOLOGY/HEMATOLOGY	
ORTHOPEDICS/PAIN MEDICINE	
PSYCHIATRY	
PULMONOLOGY	
RHEUMATOLOGY	
UROLOGY	
VASCULAR	

Drug Allergies/Sensitivities **AND** Reaction:

Preferred Pharmacy _____ Phone number: _____

Signature: _____ Date: _____