Summary Sheet

Name:

Date of Birth: Age: S W M D Sex:

Address:

Phone: Home: ( ) Work: ( )

Emergency Contact:

Allergies:

Date first seen:

Problem List

Date	Problem	Resolved

Family History:

Past History: Medical/Surgical:

Habits: Substance Abuse Y/N
Smoker? Y/N If Yes, packs/day:
Discuss Cessation? Y/N
R/X Plan:
ETOH? Y/N

Adult Immunizations

Immunization	Date	Date	Date	Date
Influenza				
Measles				
dT				
Pneumonia				
Hepatitis				
TB Testing				
Other				

Health Maintenance Procedures

Procedure Date:							
Complete History							
Mammogram							
Breast Exam							
Pap Smear							
Rectal/Prostate							
Cholesterol							
Occult Blood							
Sigmoidoscopy							
Eye Exam							
Hearing Exam							
ECG							
Other							