



<b>Name</b>		<b>DOB</b>	
<b>ADULT PATIENT THIS SECTION SHOULD BE FILLED OUT BY STAFF OR PHYSICIAN</b>			
<b>DX CODE</b>	<b>ACTIVE (CHRONIC) PROBLEMS</b>	<b>ONSET</b>	<b>HOSPITALIZATIONS / SURGERIES</b>
			<b>DATE</b>

**Patient education and counseling --- To be filled out by Patient**

1. Alcohol Use  Yes  No Amount \_\_6 pack /d ay\_\_ Recreational Drugs  Yes  No Specify occasional marijuana
2. Tobacco Smoker  Yes  No How Long 10 years\_ Pack per day 1 Ready to Quit?  Yes  No
3. Exposures: Tobacco  Yes  No Source \_\_\_\_\_ Lead  Yes  No Source \_\_\_\_\_  
 TB  Yes  No Source Neg ppd 2003 Pets  Yes  No Type \_\_\_\_\_
4. Safety Use of seat belts  Yes  No Working smoke detectors  Yes  No Use of firearms  Yes  No  
 Victim of violence  Yes  No Use of contraceptives  Yes  No Blood Transfusion  Yes  No
5. Advance Directives  Yes  No Power of Health Care \_\_\_\_\_
6. Special Diet Gluten-free Weight Concerns  Yes  No

**Health Screening Measures (enter date next to the screenings you've had below) --- TO BE FILLED OUT BY PATIENT**


**Family history --- TO BE FILLED OUT BY PATIENT. Indicate which relative by initial i.e. "b" for brother**

ADOPTED

B=Brother  
S=Sister  
M=Mother  
F=Father  
GM=Grandma  
GP=Grandpa

	Anemia	Arthritis	Arth-Osteo	Asthma	Cancer*	CHF	Diabetes+	Heart Disease	High Chol	HTN	Kidney Stone/Urinary	Migraines	Seizures	Skin Disorder	Stroke	Thyroid
Self																

Comments:

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Birth Defects:

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\* Type \_Prostate Location \_\_\_\_\_ + Type 1  Type 2  For Women Only: Gravida 6 Para 2

Reviewed By \_\_\_\_\_ Date \_\_\_\_\_ Reviewed By \_\_\_\_\_ Date \_\_\_\_\_ Reviewed By \_\_\_\_\_ Date \_\_\_\_\_ Reviewed By \_\_\_\_\_ Date \_\_\_\_\_

