

**St. Francis Medical Group
Beech Grove Family Physicians
Adult Historical Summary**

Name _____ Date of Birth _____ Sex: M or F _____ Physician _____

Patient Medical History

(check any past /current patient problems)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> confused | <input type="checkbox"/> vision | <input type="checkbox"/> problems with reproductive organs | <input type="checkbox"/> frequent falls |
| <input type="checkbox"/> unresponsive | <input type="checkbox"/> loose or chipped teeth | <input type="checkbox"/> circulation problems | <input type="checkbox"/> seizures |
| <input type="checkbox"/> eyes | <input type="checkbox"/> capped or false teeth | <input type="checkbox"/> blood clots | <input type="checkbox"/> weakness |
| <input type="checkbox"/> ears | <input type="checkbox"/> stomach problems | <input type="checkbox"/> bleeding | <input type="checkbox"/> too little sleep |
| <input type="checkbox"/> nose | <input type="checkbox"/> weight loss | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> too much sleep |
| <input type="checkbox"/> mouth | <input type="checkbox"/> weight gain | <input type="checkbox"/> stroke | <input type="checkbox"/> lung problems |
| <input type="checkbox"/> sinus | <input type="checkbox"/> bowel problems | <input type="checkbox"/> heart problems | <input type="checkbox"/> breathing problems |
| <input type="checkbox"/> throat | <input type="checkbox"/> liver problems / hepatitis | <input type="checkbox"/> thyroid | <input type="checkbox"/> chronic cough |
| <input type="checkbox"/> skin problems | <input type="checkbox"/> gallbladder | <input type="checkbox"/> diabetes | <input type="checkbox"/> TB |
| <input type="checkbox"/> rash | <input type="checkbox"/> bladder | <input type="checkbox"/> immune system problems | <input type="checkbox"/> positive TB skin test |
| <input type="checkbox"/> hives | <input type="checkbox"/> kidney | <input type="checkbox"/> bones | <input type="checkbox"/> pain: location _____ |
| <input type="checkbox"/> hearing | <input type="checkbox"/> dialysis | <input type="checkbox"/> difficulty walking | <input type="checkbox"/> cancer, location _____ |
| <input type="checkbox"/> speech | <input type="checkbox"/> abnormal pap smears | | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> implants / surgical or other metal inside the body type _____ location _____ | | | |
| <input type="checkbox"/> problems with anesthesia, describe _____ | | | |

Explain any checked items: _____

List any previous hospitalizations / surgeries / invasive procedures: _____

date of last pneumonia shot _____ date of last tetanus shot _____ date of last flu shot _____ date of last TB skin test _____

List any allergies _____

Family History

Father: living dead age at death (if applicable) _____ cause of death (if applicable) _____
 Mother: living dead age at death (if applicable) _____ cause of death (if applicable) _____

Have you had a family member with any of the following? If so, check the appropriate box.

	Father	Mother	Children	Brothers/ Sisters	Grandparents		Father	Mother	Children	Brothers/ Sisters	Grandparents
alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	high cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	genetic disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
epilepsy/seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have an advance directive? Yes No If yes, living will, durable power of attorney, health care directive.

Would you like information about advance directives? Yes No {Staff Use : Brochure given date/ initials _____ }

Social History

Marital Status : _____ Children (list names): _____

Do you live alone? yes no If you needed help to care for yourself, is there someone available to help you? yes no

Tobacco: yes no If yes, how much/day _____ x _____ years _____ Recreational drugs: yes no

Alcohol: yes no If yes, how much _____ / day _____ / week Caffeine: yes no If yes, how much / day _____

Exercise routine: _____ Occupation _____

Unusual dietary habits or herbal supplements: _____

Signature _____ Relationship to patient _____ Date _____

Staff Use Only: Factors that may affect learning: Who is to be taught: patient other; if other, relationship to patient _____

Able to read: yes no with difficulty Comments _____

Potential barriers to learning: none blind poor vision deaf decreased hearing unable to talk learning disability inability to understand memory loss language, if other than English _____

Learns best by: reading verbal instruction practicing talking watching other, _____

Are there any cultural or religious beliefs that need to be considered in the care? yes no. If yes, _____

Staff review: date / initials _____ date / initials _____ date / initials _____ date / initials _____

date / initials _____ date / initials _____ date / initials _____ date / initials _____