ADULT PROBLEM LIST

ALLERGIES: _____

_____

_____

_____

NAME: _____

INITIALLY COMPLETED _____

Yearly Update _____

Yearly Update _____

Yearly Update _____

Yearly Update _____

Yearly Update _____

CHRONIC ILLNESS	SPECIALIST	APPROX DATE	HOSPITALIZATION AND/OR SURGERIES	APPROX DATE
			Advance Directives: Yes ☐	No ☐

PREVENTATIVE MEDICINE (Enter month/year to indicate dates evaluated/performed)											**COMMENTS**
Chest X-Ray											
Complete PB											
EKG											
Mammogram											
Ophthal Exam											
Pap/Breast Exam											
Prostate/PSA											
Rectal/Gualac											
Sigmoid/Color Exam											
Lab Profile											
Other											

Personal/Social History (Please fill in information or N/A)

Occupation _____ Smoke/Tobac _____

Marital Status _____ Caffeine _____

Children _____ Alcohol _____

Recreation Drugs _____ Exercise _____

Menstrual History

P _____ G _____

Abort (Spon/Elect) _____

Menarchs _____

Family History (Has any member of family ever had? (Indicate relationship or N/A)

Diabetes _____ Cancer _____ Alcoholism _____

Stroke _____ Glaucoma _____ Substance Abuse _____

Heart Disease/MI _____ Asthma _____ Psych _____

High BP/Hyperten _____ Tuberculosis _____ Other _____

Epilepsy _____ Empitysema _____

Flu Vaccine																	
Pneumovax																	
TD																	

No Show Letter Sent					Comments:

Reviewed (MD) _____