

## McLaren Print System Order

Order No: 44032 Reprint Previous Order No: 5452  
 Order Date: 2019-03-28  
 User: Shantell Moore  
 Phone: 231-679-3915

Ship Location: McLaren Davison CMC  
 10090 E Lippincott Blvd  
 Davison, MI 48423

### Forms

Quantity: 500  
 Paragon Dept No: 64103  
 Dept Name: McLaren Davison CMC  
 Company Number: 810

Order Total Price: 0.00

Item Number: MM-3380  
 Item Description: Adult Patient History  
 Revision Date: 10/2018  
 Print: 2 sided black and white  
 Paper: 20# White Text  
 Size: 8.5 x 11  
 Fold:  
 Finish:  
 Drill: None  
 Misc Info:

McLaren Medical Group  
**ADULT PATIENT HISTORY**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Sex:  M  F Birthdate: \_\_\_\_\_

<p><b>MEDICATIONS</b> (including over-the-counter medications, herbal supplements)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>MEDICAL PROBLEMS</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>PREVIOUS HOSPITALIZATIONS/SURGERIES/BLOOD TRANSFUSIONS</b>  <small>(Date, Reason, Hospital/Physician)</small></p> <p>_____</p> <p>_____</p> <p><b>SAFETY:</b></p> <p>1. Have you fallen in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Do you buckle your safety belt when driving or riding? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Do you wear a helmet when riding a bicycle, motorcycle, etc. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Do you have current &amp; operational smoke detectors and carbon monoxide detectors? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Do you have an updated First Aid kit in your home? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. <input type="checkbox"/> No <input type="checkbox"/> Yes Do you feel safe at home?  <small>to/has anyone ever</small>          - hit you? <input type="checkbox"/> Yes <input type="checkbox"/> No          - assaulted you or put you down? <input type="checkbox"/> Yes <input type="checkbox"/> No          - threatened you? <input type="checkbox"/> Yes <input type="checkbox"/> No          - forced sex upon you? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If you answered "yes" to any part of number 6, would you like help dealing with this situation? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Do you keep firearms in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. If you answered "yes" to number 7, do you take safety precautions with firearms in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Do you use sunscreen regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>ALLERGIES:</b></p> <p>_____</p> <p>_____</p> <p>Latex/tape allergy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>FAMILY HISTORY</b>  <small>If any of these relatives have had any of these conditions, please check the appropriate box.</small></p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <td></td> <td>Grandfather</td> <td>Father</td> <td>Mother</td> <td>Sister</td> <td>Brother</td> <td>Grandmother</td> </tr> <tr> <td>Diabetes</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Cancer</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Let Type(s)</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Heart Disease</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Stroke</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>High blood pressure</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Seizures</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Gout/rheum.</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Thyroid Disease</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Kidney Disease</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Mental Stress</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table> <p>Please indicate the date of your:</p> <p>Last Tetanus shot _____</p> <p>Last Pneumonia shot _____</p> <p>Last MMR shot _____</p> <p>Last Hepatitis B shot _____</p> <p>Last eye exam _____</p> <p>Last dental exam _____</p> <p>Last TB test _____</p> <p>Last PSA test (men) _____</p> <p>Last PAP (women) _____</p> <p>Last Mammogram _____</p> <p>Last Bone Density _____</p> <p>Last Colonoscopy _____</p>		Grandfather	Father	Mother	Sister	Brother	Grandmother	Diabetes							Cancer							Let Type(s)							Heart Disease							Stroke							High blood pressure							Seizures							Gout/rheum.							Thyroid Disease							Kidney Disease							Mental Stress						
	Grandfather	Father	Mother	Sister	Brother	Grandmother																																																																															
Diabetes																																																																																					
Cancer																																																																																					
Let Type(s)																																																																																					
Heart Disease																																																																																					
Stroke																																																																																					
High blood pressure																																																																																					
Seizures																																																																																					
Gout/rheum.																																																																																					
Thyroid Disease																																																																																					
Kidney Disease																																																																																					
Mental Stress																																																																																					

**SOCIAL HISTORY**

Tobacco use (smoker or chaser)  Yes  No If yes, what? \_\_\_\_\_ If no, have you in the past?  Yes  No

How much? \_\_\_\_\_ per day x \_\_\_\_\_ years

Alcohol use  Yes  No If yes, what? \_\_\_\_\_ How much? \_\_\_\_\_ per day \_\_\_\_\_ x per week

Recreational Drugs  Yes  No If yes, what? \_\_\_\_\_ How much? \_\_\_\_\_ per day \_\_\_\_\_ x per week

Coffee  Yes  No If yes, amount \_\_\_\_\_ per day

Exercise  Yes  No If yes, specify type \_\_\_\_\_ How often? \_\_\_\_\_

Occupation \_\_\_\_\_ Contact with chemicals, lead, excessive noise or blood/body fluids at work  Yes  No  
(Circle those appropriate)

**ADVANCE** Do you have an Advance Directive, i.e., written instructions for your family and health care provider in the event that you cannot make a decision yourself about your care?  Yes  No

Would you like information on Advance Directives?  Yes  No Info given  self  other

(SEE REVERSE)