

## McLaren Print System Order

Order No: 46041 Reprint Previous Order No: 5452  
 Order Date: 2019-06-06  
 User: Kathy Nedorw  
 Phone: (810) 985-8144

Ship Location: Dr. Patel  
 1216 Richardson  
 Port Huron, MI 48060

### Forms

Quantity: 500  
 Paragon Dept No: 7412  
 Dept Name: MPH Family Medicine  
 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. If you feel safe at home? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>    - Has anyone ever</p> <p>        - hit you? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>        - insulted you or put you down? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>        - threatened you? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>        - 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>    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>8. 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>    List 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>    Specify</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Gout</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> <p><b>SOCIAL HISTORY</b></p> <p>Tobacco use (smoker or chaser) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what? _____ If no, have you in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>How much? _____ per day x _____ years</p> <p>Alcohol use <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what? _____ How much? _____ per day _____ x per week</p> <p>Recreational Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what? _____ How much? _____ per day _____ x per week</p> <p>Coffee <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount _____ per day</p> <p>Exercise <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify type _____ How often? _____</p> <p>Occupation _____ Contact with chemicals, lead, explosive noise or blood/body fluids at work? <input type="checkbox"/> Yes <input type="checkbox"/> No  <small>(Check those appropriate)</small></p> <p><b>ADVANCE</b> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Would you like information on Advance Directives? <input type="checkbox"/> Yes <input type="checkbox"/> No Info given <input type="checkbox"/> self <input type="checkbox"/> other</p> <p style="text-align: center;">(SEE REVERSE)</p>		Grandfather	Father	Mother	Sister	Brother	Grandmother	Diabetes							Cancer							List Type(s)							Heart Disease							Stroke							High blood pressure							Specify							Gout							Thyroid Disease							Kidney Disease							Mental Stress						
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