

McLaren Print System Order

Order No: 5775
Order Date: 2014-09-15
User: Melissa Hayes
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Ship Location: Pickard Clinic
4639 E. Pickard St., Suite A
Mt. Pleasant, MI 48858

Forms

Quantity: 100
Paragon Dept No: 81075050566420
Dept Name: Pickard Clinic
Company Number: 810

Order Total Price: 0.00

Form Number: MM-35
Form Description: Annual Adult Patient History Update
Revision Date: 10/2013
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish: None
Drill: None

McLaren Medical Group
ANNUAL ADULT PATIENT HISTORY UPDATE

Patient Name _____ Date _____ Sex M F Birthdate _____

MEDICATIONS No new medications in the past year? No
Include over the counter medications, herbal supplements

Dr.	Dr.
Dr.	Dr.
Dr.	Dr.
Dr.	Dr.

VISITS No new visits any specialist? No
List their names and city

Dr.	City
Dr.	City
Dr.	City
Dr.	City

ALLERGIES None
None otherwise

EMERGENCY No Change
Any changes to health conditions of family in the past year?

HOSPITALIZATIONS/URGENT CARE/TRANSFUSIONS
Any new in the past year? (date, reason, hospital, physician)

SOCIAL HISTORY

Tobacco use (smoke or chew) Yes No ... If yes, what? _____ How much? _____ per day x _____ years

Alcohol use Yes No ... If yes, what? _____ How much? _____ per day _____ per wk

Recreational Drug Yes No ... If yes, what? _____ How much? _____ per day _____ per wk

Coffee Yes No ... If yes, what? _____ How much? _____ per day

Exercise Yes No ... If yes, type? _____ How often? _____

Occupation _____ Contact with chemicals, lead, asbestos, noise or blood/body fluids at work? Yes No
(include those applicable)

SAFETY: Do you feel unsafe at home? YES NO - Have you fallen in the last year? YES NO
Has any one ever ... hit you? YES NO - Insulted you or put you down? YES NO
Threatened you? YES NO - Forced sex upon you? YES NO
If you answered "yes" to any part, would you like help dealing with this situation? YES NO

DEPRESSION - Check box if any time in the last 4 weeks you have experience any of the following:

- Little interest or pleasure in doing things?
- Trouble falling or staying asleep, or sleeping too much?
- Feeling down, depressed, or hopeless?
- Feeling bad about yourself or that you are a failure or have let your self or your family down?
- Feeling tired or having little energy?
- Trouble concentrating on things, such as reading the news paper or watching television?
- Poor appetite or overeating?
- Thoughts that you would be better off dead or thoughts of hurting yourself in some way?
- Worried or spending too much time that other people could harm or mistreat you? Or the appetite being so big that you have been losing a lot more than usual?

Please Sign Below

Patient (or Personal Representative) _____ Relationship to Patient _____ Date _____

Physician _____ Date/Time _____