

McLaren Print System Order

Order No: 59675 Reprint Previous Order No: 6259
 Order Date: 2021-01-14
 User: REGINA NEAL
 Phone: 5867915250

Ship Location: McLaren Macomb Family Medicine
 35103 Silvano
 Clinton twp, Michigan 48035

Forms

Quantity: 500
 Paragon Dept No: 71000
 Dept Name:
 Company Number: 260

Order Total Price: 0.00

Item Number: MM-3380-M
 Item Description: Adult Patient History
 Revision Date: 10/2014
 Print: 2 sided black and white
 Paper: 20# White Text
 Size: 8.5 x 11
 Fold:
 Finish:
 Drill: None
 Misc Info:

McLaren Macomb
ADULT PATIENT HISTORY

Patient Name: _____ Date: _____ Sex: M F Birthdate: _____

<p>MEDICATIONS (including over-the-counter medications, herbal supplements)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>MEDICAL PROBLEMS</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>PREVIOUS HOSPITALIZATIONS/SURGERIES/BLOOD TRANSFUSIONS (date, reason, hospital/physician)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>SAFETY:</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 & 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. a) Do you feel unsafe at home? to have anyone enter <input type="checkbox"/> Yes <input type="checkbox"/> No - if you? <input type="checkbox"/> Yes <input type="checkbox"/> No - insulted 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 (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 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>ALLERGIES:</p> <p>_____</p> <p>_____</p> <p>Latex/tape allergy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>FAMILY HISTORY (Any of these relatives have had any of these conditions, please check the appropriate box)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr><td>Diabetes</td><td></td><td></td></tr> <tr><td>Cancer</td><td></td><td></td></tr> <tr><td>Heart Disease</td><td></td><td></td></tr> <tr><td>Stroke</td><td></td><td></td></tr> <tr><td>High blood pressure</td><td></td><td></td></tr> <tr><td>Seizures</td><td></td><td></td></tr> <tr><td>Alzheimer</td><td></td><td></td></tr> <tr><td>Thyroid Disease</td><td></td><td></td></tr> <tr><td>Kidney Disease</td><td></td><td></td></tr> <tr><td>Mental illness</td><td></td><td></td></tr> </tbody> </table> <p>Please indicate the date of your:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tbody> <tr><td>Last Tetanus shot</td><td></td></tr> <tr><td>Last Pneumonia shot</td><td></td></tr> <tr><td>Last MMR shot</td><td></td></tr> <tr><td>Last Hepatitis B shot</td><td></td></tr> <tr><td>Last eye exam</td><td></td></tr> <tr><td>Last dental exam</td><td></td></tr> <tr><td>Last TB test</td><td></td></tr> <tr><td>Last PSA test (men)</td><td></td></tr> <tr><td>Last HPIV (women)</td><td></td></tr> <tr><td>Last Mammogram</td><td></td></tr> <tr><td>Last Bone Density</td><td></td></tr> <tr><td>Last Colonoscopy</td><td></td></tr> </tbody> </table>		Yes	No	Diabetes			Cancer			Heart Disease			Stroke			High blood pressure			Seizures			Alzheimer			Thyroid Disease			Kidney Disease			Mental illness			Last Tetanus shot		Last Pneumonia shot		Last MMR shot		Last Hepatitis B shot		Last eye exam		Last dental exam		Last TB test		Last PSA test (men)		Last HPIV (women)		Last Mammogram		Last Bone Density		Last Colonoscopy	
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<p>SOCIAL HISTORY</p> <p>Tobacco use (smoked or chewed) <input type="checkbox"/> yes <input type="checkbox"/> no, if yes, what? _____ 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, source _____ 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, heat, excessive noise or blood/body fluids at work: <input type="checkbox"/> yes <input type="checkbox"/> no (circle those applicable)</p>																																																										

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 (staff use)

(SEE REVERSE)