

McLaren Print System Order

Order No: 6077
 Order Date: 2014-09-26
 User: Angela DeLaRosa
 Phone: 3720 Katalin Ct, Suite 201 (989) 893-9705

Ship Location: McLaren Bay Region Family Medicine/Attn Angela DeLaRosa
 3720 Katalin Ct
 Bay City, MI 48706

Forms
 Quantity: 1000
 Paragon Dept No: 60841
 Dept Name: McLaren Medical Group
 Company Number: 810

Order Total Price: 0.00

Form Number: MM-3380
 Form Description: Adult Patient History
 Revision Date: 11/2013
 Print: 2 sided black and white
 Paper: 20# White Text
 Size: 8.5 x 11
 Fold:
 Finish:
 Drill: None

McLaren Medical Group
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 Fire-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 someone enter <input type="checkbox"/> yes <input type="checkbox"/> no - hit you? <input type="checkbox"/> yes <input type="checkbox"/> no - threatened you? <input type="checkbox"/> yes <input type="checkbox"/> no - harassed you upon you? <input type="checkbox"/> yes <input type="checkbox"/> no b) 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>_____</p> <p>LateX/rape allergy <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>FAMILY HISTORY If 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;"> <tr> <td></td> <td>Grandfather</td> <td>Father</td> <td>Mother</td> <td>Sister</td> <td>Brother</td> <td>Uncle</td> <td>Aunt</td> <td>Nephew</td> <td>Niece</td> </tr> <tr> <td>Tuberculosis</td> <td></td> <td></td> <td></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> <td></td> <td></td> <td></td> </tr> <tr> <td>Heart Disease</td> <td></td> <td></td> <td></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> <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> <td></td> <td></td> <td></td> </tr> <tr> <td>Seizures</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Diabetes</td> <td></td> <td></td> <td></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> <td></td> <td></td> <td></td> </tr> <tr> <td>Kidney Disease</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Mental illness</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table> <p>Please indicate the date of your:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <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 PEP (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> </table>		Grandfather	Father	Mother	Sister	Brother	Uncle	Aunt	Nephew	Niece	Tuberculosis										Cancer										Heart Disease										Stroke										High blood pressure										Seizures										Diabetes										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 PEP (women)	_____	Last Mammogram	_____	Last Bone Density	_____	Last Colonoscopy	_____
	Grandfather	Father	Mother	Sister	Brother	Uncle	Aunt	Nephew	Niece																																																																																																																														
Tuberculosis																																																																																																																																							
Cancer																																																																																																																																							
Heart Disease																																																																																																																																							
Stroke																																																																																																																																							
High blood pressure																																																																																																																																							
Seizures																																																																																																																																							
Diabetes																																																																																																																																							
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 PEP (women)	_____																																																																																																																																						
Last Mammogram	_____																																																																																																																																						
Last Bone Density	_____																																																																																																																																						
Last Colonoscopy	_____																																																																																																																																						

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 x _____ per week

Recreational Drugs yes no, if yes, what? _____ How much? _____ per day x _____ per week

Coffee yes no, if yes, amount _____ amount _____ per day _____ per week

Exercise yes no, if yes, specify type _____ How often? _____

Occupation: _____ Contact with chemicals, heat, excessive noise or blood/body fluids at work? yes no (circle those applicable)

ADVANCE DIRECTIVES: 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 L. staff use

(SEE REVERSE)