

## McLaren Print System Order

Order No: 6224  
 Order Date: 2014-10-02  
 User: Louann Harmon  
 Phone: 5179759844

Ship Location: Louann Harmon  
 1035 Charlevoix Dr, ste 200  
 Grand Ledge, MI 48837

### Forms

Quantity: 500  
 Paragon Dept No: 67325  
 Dept Name: MGL Grand Ledge Health Center  
 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 \_\_\_\_\_

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**MEICATIONS**  Yes  No  
 Are you taking any medications in the past year? (Include over-the-counter medications, herbal supplements)


**VITAMINS**  Yes  No  
 Are you taking any vitamins? (List their names and city)


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**ALLERGIES**  None  
 Have any allergies?


**EMERGENCY**  No Change  
 Are there any changes to health conditions of family in the past year?



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


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**SOCIAL HISTORY**

Tobacco use (smoke or chew)  Yes  No \_\_\_\_\_ If yes, what \_\_\_\_\_ How much \_\_\_\_\_ per day \_\_\_\_\_ years

Alcohol use  Yes  No \_\_\_\_\_ If yes, what \_\_\_\_\_ How much \_\_\_\_\_ per day \_\_\_\_\_ years wk

Recreational Drug  Yes  No \_\_\_\_\_ If yes, what \_\_\_\_\_ How much \_\_\_\_\_ per day \_\_\_\_\_ years 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)

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**SAFETY:** Do you feel unsafe at home?  YES  NO - Have you fallen in the last year?  YES  NO  
 Has anything 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

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**DEPRESSION** - Check box if any item in the list "I" would you have experience of 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 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 eating a lot more than usual?

\_\_\_\_\_  
 Please Sign Below

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Patient (or Personal Representative) \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Date \_\_\_\_\_

Physician \_\_\_\_\_ Date/Time \_\_\_\_\_