

## McLaren Print System Order

Order No: 6561  
 Order Date: 2014-10-17  
 User: Rebecca Colburn  
 Phone: 810 496-2507

Ship Location: Fenton Admin / Rebecca  
 2420 Owen Rd.  
 Fenton , MI 48430

### Forms

Quantity: 1000  
 Paragon Dept No: 64000  
 Dept Name: 64000  
 Company Number: 810

Order Total Price: 0.00

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

McLaren Medical Group  
 ANNUAL ADULT PATIENT HISTORY UPDATE

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Sex:  M  F Birthdate: \_\_\_\_\_

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


**OPERATIONS**  
 Are you making any operations?  No  Yes  
 List their names and city


**ALLERGIES**  None  Have  
 New allergies


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

List condition and check relationship	M	F	M	F	M	F

**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 Drugs  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 hazardous fluids at work)  Yes  No  
(check 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** - Indicate if any item in the list applies to you (have symptoms 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 self or your family down?
- Feeling tired or having little energy?
- Trouble concentrating on things, such as reading the news paper or watching television?
- Loss of appetite or increasing?
- Thoughts that you would be better off dead or in thoughts of hurting yourself in some way?
- Slowing or speaking so slowly that other people could have trouble hearing you? Or the opposite, being so talkative or so fast that others find it hard to understand?

Please Sign Below

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

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

444-111-111