

McLaren Print System Order

Order No: 57650 Reprint Previous Order No: 5452
 Order Date: 2020-10-15
 User: Chelsey Johnson
 Phone: 517-913-3820

Ship Location: **ATTN: Chelsey (Operations Supervisor)**
 1540 Lake Lansing Road STE 202
 Lansing, MI 48912

Forms
 Quantity: 1000
 Paragon Dept No: 68025
 Dept Name: McLaren Family Medicine & Lipidology
 Company Number: 810

Order Total Price: 0.00

Item Number: MM-3380
 Item Description: Adult Patient History
 Revision Date: 10/2018
 Print: 2 sided black and white
 Paper: 20# White Text
 Size: 8.5 x 11
 Fold:
 Finish:
 Drill: None
 Misc Info:

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 <small>(Date, Reason, Hospital/Physician)</small></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. If you feel safe at home? <small>to Has anyone ever</small> <small>- hit you?</small> <input type="checkbox"/> Yes <input type="checkbox"/> No <small>- assaulted you or put you down?</small> <input type="checkbox"/> Yes <input type="checkbox"/> No <small>- threatened you?</small> <input type="checkbox"/> Yes <input type="checkbox"/> No <small>- forced sex upon you?</small> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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 keep firearms in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. If you answered "yes" to number 7, do you take safety precautions with firearms in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. 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 <small>If any of these relatives have had any of these conditions, please check the appropriate box.</small></p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <td></td> <td>Grandfather</td> <td>Father</td> <td>Mother</td> <td>Brother</td> <td>Sister</td> <td>Uncle</td> <td>Aunt</td> <td>Nephew</td> <td>Niece</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>Cancer</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>Let Type(s)</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>Gout</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> <p>Last Tetanus shot _____</p> <p>Last Pneumonia shot _____</p> <p>Last MMR shot _____</p> <p>Last Pap (women) _____</p> <p>Last eye exam _____</p> <p>Last dental exam _____</p> <p>Last TB test _____</p> <p>Last PSA test (men) _____</p> <p>Last PIP (men) _____</p> <p>Last Mammogram _____</p> <p>Last Bone Density _____</p> <p>Last Colonoscopy _____</p>		Grandfather	Father	Mother	Brother	Sister	Uncle	Aunt	Nephew	Niece	Diabetes										Cancer										Let Type(s)										Heart Disease										Stroke										High blood pressure										Seizures										Gout										Thyroid Disease										Kidney Disease										Mental Illness									
	Grandfather	Father	Mother	Brother	Sister	Uncle	Aunt	Nephew	Niece																																																																																																																
Diabetes																																																																																																																									
Cancer																																																																																																																									
Let Type(s)																																																																																																																									
Heart Disease																																																																																																																									
Stroke																																																																																																																									
High blood pressure																																																																																																																									
Seizures																																																																																																																									
Gout																																																																																																																									
Thyroid Disease																																																																																																																									
Kidney Disease																																																																																																																									
Mental Illness																																																																																																																									

SOCIAL HISTORY

Tobacco use (smoker or chaser) Yes No If yes, what? _____ If no, have you in the past? Yes No

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 _____ per day

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

Occupation _____ Contact with chemicals, lead, excessive noise or blood/body fluids at work? Yes No
(Check those appropriate)

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 self other

(SEE REVERSE)