McLaren Medical Group

ADULT PATIENT HISTORY

Patient Name: ________________________ Date: _______________ Sex: ❑ M ❑ F Birthdate ______________

MEDICATIONS (including over-the-counter medications, herbal supplements)

____

____

____

____

MEDICAL PROBLEMS

____

____

____

PREVIOUS HOSPITALIZATIONS/SURGERIES/BLOOD TRANSFUSIONS

(date, reason, hospital/physician)

____

____

____

SAFETY:

1.	Have you fallen in the last year?	❑ Yes	❑ No
2.	Do you buckle your safety belt when driving or riding?	❑ Yes	❑ No
3.	Do you wear a helmet when riding a bicycle, motorcycle, etc.	❑ Yes	❑ No
4.	Do you have current & operational smoke detectors and carbon monoxide detectors?	❑ Yes	❑ No
5.	Do you have an updated First-Aid Kit in your home?	❑ Yes	❑ No
6.	a) Do you feel unsafe at home?	❑ Yes	❑ No
	b) Has anyone ever		
	- hit you?	❑ Yes	❑ No
	- insulted you or put you down?	❑ Yes	❑ No
	- threatened you?	❑ Yes	❑ No
	- forced sex upon you?	❑ Yes	❑ No
	c) If you answered “yes” to any part of number 6, would you like help dealing with this situation?	❑ Yes	❑ No
7.	Do you take safety precautions with firearms in the home?	❑ Yes	❑ No
8.	Do you use sunscreen regularly?	❑ Yes	❑ No

ALLERGIES:

____

____

____

____

Latex/tape allergy ❑ Yes ❑ No

FAMILY HISTORY

If any of these relatives have had any of these conditions, please check the appropriate box

	Mother	Father	Sister / Brother	Grandparents
Diabetes				
Cancer				
Heart Disease				
Stroke				
High blood pressure				
Seizures				
Glaucoma				
Thyroid Disease				
Kidney Disease				
Mental Illness				

Please indicate the date of your:

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 PAP (women)	
Last Mammogram	
Last Bone Density	
Last Colonoscopy	

SOCIAL HISTORY

	Use/activity in the past
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	❑
Caffeine: ❑ yes ❑ no If yes, source ______________ 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
(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 ☐ (staff use)

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(SEE REVERSE)

McLaren Medical Group

MEDICAL HISTORY

(Check all that apply)

Patient Name: ____________________________________ Birthdate ______________

GENERAL:
- ❑ fever ❑ chills ❑ sweats ❑ fatigue
- ❑ sleeplessness ❑ headaches ❑ dizziness
- ❑ weakness ❑ **loss of appetite**
- ❑ **weight loss/gain** ❑ **eating problems**

EYES:
- ❑ drainage ❑ redness ❑ itching
- ❑ blurring ❑ double vision

EARS, NOSE, THROAT, MOUTH:
- ❑ pain/pressure (areas) ________________
- ❑ congestion/draining (areas) ________________
- ❑ sneezing ❑ decreased hearing
- ❑ bad breath ❑ frequent nose bleeds
- ❑ problem with teeth/gums ❑ hoarseness

RESPIRATORY:
- ❑ shortness of breath ❑ cough
- ❑ wheezing ❑ blood sputum
- ❑ congestion/heaviness in chest
- ❑ asthma ❑ tuberculosis

CARDIOVASCULAR:
- ❑ high blood pressure
- ❑ chest pain/pressure ❑ irregular/rapid beat
- ❑ jaw/shoulder/arm pain
- ❑ excessive sweating ❑ poor coloring
- ❑ swelling/fluid retention ❑ rheumatic fever
- ❑ varicose veins/phlebitis

GASTROINTESTINAL:
- ❑ **stomach problems**
- ❑ **indigestion/heartburn** ❑ **nausea** ❑ **vomiting**
- ❑ gas ❑ **diarrhea** ❑ **constipation**
- ❑ blood in stools ❑ blood in vomitus
- ❑ hemorrhoids ❑ pain
- ❑ rectal bleeding ❑ **change in bowel habits**
- ❑ gallbladder disease ❑ hepatitis
- ❑ special diet

GENITOURINARY:
- ❑ kidney/bladder problems
- ❑ burning/painful urination ❑ frequency
- ❑ night urination ❑ blood in urine
- ❑ genital sores ❑ vaginal/penile discharge
- ❑ pelvic pain ❑ itching ❑ bleeding
- ❑ prostate disease
- ❑ perform testicular self exam

MUSCULOSKELETAL:
- ❑ body ache ❑ stiffness (area) ____________________
- ❑ swelling ❑ joint pain (area) ____________________
- ❑ warmth ❑ arthritis/gout ❑ difficulty walking
- ❑ Walker/Cane ❑ Wheelchair

SKIN and/or BREAST:
- ❑ wounds (area) ____________________
- ❑ sores (area) ____________________
- ❑ dryness ❑ itching ❑ rashes
- ❑ discoloration ❑ tightening ❑ bruise easily
- ❑ perform breast self exam

NEUROLOGICAL:
- ❑ tingling (area) ______________________
- ❑ numbness ❑ paralysis
- ❑ convulsions/seizures

PSYCHIATRIC:
- ❑ stress ❑ anxiety ❑ agitation ❑ memory loss
- ❑ depression (Check box if any time in the last 2 weeks you have experienced 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 yourself or your family down?
- ❑ Feeling tired or having little energy?
- ❑ Trouble concentrating on things, such as reading the newspaper or watching television?
- ❑ Poor appetite or overeating?
- ❑ Thoughts that you would be better off dead or thoughts of hurting yourself in some way?
- ❑ Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual?

ENDOCRINE:
- ❑ thyroid trouble ❑ heat or cold intolerance
- ❑ excessive sweating ❑ thirst ❑ hunger ❑ **diabetes**

HEMATOLOGIC/LYMPHATIC:
- ❑ swollen glands ❑ tenderness of glands ❑ **anemia**

ALLERGIC/IMMUNOLOGIC:
- ❑ respiratory distress ❑ hives ❑ itching
- ❑ difficulty swallowing ❑ swelling
- ❑ hay fever

REPRODUCTIVE HEALTH:
- ❑ suspected pregnancy
- ❑ currently sexually active
- ❑ condom use
- ❑ history of sexually transmitted disease
- ❑ sexual problems

Information given by: ______________________ Relationship to patient: ______________________ Date: ________________

OFFICE USE ONLY

Bold print in medical history may indicate dietician/nutritional assessment is required.

Special Learning Needs: ❑ No ❑ Yes, specify: ____

Language Preference for Healthcare: ❑ English ❑ Other specify: ______________________________________

Provider's Signature:____ Date/Time: ________________