McLaren Medical Group
ANNUAL ADULT PATIENT HISTORY UPDATE

Patient Name: _____ Date: _____ Sex: ☐M ☐F Birthdate: _____

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

1)	5)
2)	6)
3)	7)
4)	8)

SPECIALISTS
Are you seeing any specialists? ☐No
List their names and city

1)
2)
3)
4)

ALLERGIES ☐None
New allergies

FAMILY HISTORY ☐No Change
Any changes to health conditions of family in the past year?

List condition and check relationship	Mother	Father	Siblings	Grandparents

HOSPITALIZATIONS/SURGERIES/BLOOD TRANSFUSIONS
Any new in the past year? (date, reason, hospital, physician)

1)
2)
3)

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 wk

Recreational Drugs: ☐ Yes ☐ No ..... If yes, what?_____ How much?_____per day _____x per wk

Caffeine: ☐ Yes ☐ No .... If yes, what?_____ Amount?_____per day

Exercise: ☐ Yes ☐ No .... If yes, type? _____ How often?_____

Occupation: _____ Contact with chemicals, lead, excessive noise or blood/body fluids at work: ☐ Yes ☐ No (circle 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 (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 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?
- ☐ 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?

Please Sign Below

_____ _____ _____
Patient (or Personal Representative) Relationship to Patient Date

_____ _____
Physician Date/Time

MM-35 (10/13)