

McLaren Print System Order

Order No: 6304
 Order Date: 2014-10-06
 User: Rebecca Colburn
 Phone: 810 496-2507

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

Forms

Quantity: 500
 Paragon Dept No: 64000
 Dept Name: 64000
 Company Number: 810

Order Total Price: 0.00

Form Number: MM-35
 Form 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

McLaren Medical Group
ANNUAL ADULT PATIENT HISTORY UPDATE

Patient Name _____ Date _____ Sex M F Birthdate _____

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

VITALS Yes No
 Are you seeing any specialists? No
 List their names and city

ALLERGIES None
 None Allergic

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

List condition and check relationship	Name	Date	Status	Remarks

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 Drug 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 blood/body fluids at work? Yes No
(Indicate 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 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 self 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?
- Worried or spending too much time that other people could harm you or if the appetite being so big or so small that you have been losing around a lot more than usual?

 Please Sign Below

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

Physician _____ Date/Time _____