

McLaren Print System Order

Order No: 7015
 Order Date: 2014-11-09
 User: Melissa Hayes
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Ship Location: Pickard Clinic
 4639 E. Pickard St., Suite A
 Mt. Pleasant, MI 48858

Forms

Quantity: 100
 Paragon Dept No: 81075050566420
 Dept Name: Pickard Clinic
 Company Number: 810

Order Total Price: 0.00

Item Number: MM-35
 Item Description: Annual Adult Patient History Update
 Revision Date: 10/2013
 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 No
 Any new medications in the past year? Yes
 Include over the counter medications, herbal supplements

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

ALLERGIES None
 New allergies

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

List condition and health relationship	Males	Females	Illness	Injury	Other

HOSPITALIZATIONS SURGERIES BLOOD 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 Yes No (Center with those who had accidents motor or household/fault 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 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 noisy 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