

McLaren Print System Order

Order No: 7120
 Order Date: 2014-11-13
 User: Denise Turner
 Phone: 810 342-1711

Ship Location: Denise Turner
 1314 S. Linden Rd., Suite C
 Flint, MI 48532

Forms
 Quantity: 1000
 Paragon Dept No: 63550
 Dept Name: McLaren-Flint Community Medical Center
 Company Number: 810

Order Total Price: 0.00

Item Number: MM-3380
 Item Description: Adult Patient History
 Revision Date: 11/2013
 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 (date, reason, hospital/physician)</p> <p>_____</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. a. Do you feel unsafe at home? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">b. Has anyone ever:</p> <p style="padding-left: 40px;">- hit you? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 40px;">- threatened you or put you down? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 40px;">- threatened you? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 40px;">- forced sex upon you? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 40px;">c. 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 take safety precautions with firearms in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. 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 If any of these relatives have had any of these conditions please check the appropriate box</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td></td> <td>Yes</td> <td>No</td> </tr> <tr> <td>Diabetes</td> <td></td> <td></td> </tr> <tr> <td>Cancer</td> <td></td> <td></td> </tr> <tr> <td>Heart Disease</td> <td></td> <td></td> </tr> <tr> <td>Stroke</td> <td></td> <td></td> </tr> <tr> <td>High blood pressure</td> <td></td> <td></td> </tr> <tr> <td>Seizures</td> <td></td> <td></td> </tr> <tr> <td>Cholesterol</td> <td></td> <td></td> </tr> <tr> <td>Thyroid Disease</td> <td></td> <td></td> </tr> <tr> <td>Kidney Disease</td> <td></td> <td></td> </tr> <tr> <td>Mental Stress</td> <td></td> <td></td> </tr> </table> <p>Please indicate the date of year:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>Last Tetanus Shot</td> <td></td> </tr> <tr> <td>Last Pneumonia shot</td> <td></td> </tr> <tr> <td>Last MMR shot</td> <td></td> </tr> <tr> <td>Last Hepatitis B shot</td> <td></td> </tr> <tr> <td>Last eye exam</td> <td></td> </tr> <tr> <td>Last dental exam</td> <td></td> </tr> <tr> <td>Last T3 test</td> <td></td> </tr> <tr> <td>Last PSA test (men)</td> <td></td> </tr> <tr> <td>Last PAP (women)</td> <td></td> </tr> <tr> <td>Last Mammogram</td> <td></td> </tr> <tr> <td>Last Bone Density</td> <td></td> </tr> <tr> <td>Last Colonoscopy</td> <td></td> </tr> </table>		Yes	No	Diabetes			Cancer			Heart Disease			Stroke			High blood pressure			Seizures			Cholesterol			Thyroid Disease			Kidney Disease			Mental Stress			Last Tetanus Shot		Last Pneumonia shot		Last MMR shot		Last Hepatitis B shot		Last eye exam		Last dental exam		Last T3 test		Last PSA test (men)		Last PAP (women)		Last Mammogram		Last Bone Density		Last Colonoscopy	
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SOCIAL HISTORY

Tobacco use (cigarette 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

Coffee Yes No, if yes, source _____ amount _____ per day

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

Occupation _____ Contact with chemicals, heat, excessive noise or blood/body fluids at work Yes No (circle those applicable)

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: L, (self use)

(SEE REVERSE)