

McLaren Print System Order

Order No: 8010
 Order Date: 2015-01-07
 User: Dolores Guy
 Phone: Dodge Park

Ship Location: Dolores Guy
 35111 Dodge Park
 Sterling Heights, MI 48312

Forms
 Quantity: 100
 Paragon Dept No: 72500
 Dept Name: McLaren Pediatrics
 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 (State 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="margin-left: 20px;">b. Has anyone ever:</p> <p style="margin-left: 40px;">- hit you? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="margin-left: 40px;">- threatened you or put you down? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="margin-left: 40px;">- threatened you? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="margin-left: 40px;">- forced sex upon you? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="margin-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>SOCIAL HISTORY</p> <p>Tobacco use (cigarette or chew) <input type="checkbox"/> yes <input type="checkbox"/> no. If yes, what? _____ How much? _____ per day x _____ years <input type="checkbox"/></p> <p>Alcohol use <input type="checkbox"/> yes <input type="checkbox"/> no. If yes, what? _____ How much? _____ per day x _____ per week <input type="checkbox"/></p> <p>Recreational Drugs <input type="checkbox"/> yes <input type="checkbox"/> no. If yes, what? _____ How much? _____ per day x _____ per week <input type="checkbox"/></p> <p>Coffee <input type="checkbox"/> yes <input type="checkbox"/> no. If yes, source _____ amount _____ per day <input type="checkbox"/></p> <p>Exercise <input type="checkbox"/> yes <input type="checkbox"/> no. If yes, specify type _____ How often? _____ <input type="checkbox"/></p> <p>Occupation _____ Contact with chemicals, heat, excessive noise or blood/body fluids at work? <input type="checkbox"/> yes <input type="checkbox"/> no (circle those applicable)</p> <p>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? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Would you like information on Advance Directives? <input type="checkbox"/> yes <input type="checkbox"/> no Info given: L. (self use)</p> <p style="text-align: center;">(SEE REVERSE)</p>	<p>ALLERGIES:</p> <p>_____</p> <p>_____</p> <p>Latex/rape 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; text-align: center;"> <tr> <td></td> <td>Grandfather</td> <td>Father</td> <td>Mother</td> <td>Sister</td> <td>Brother</td> </tr> <tr> <td>Diabetes</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Cancer</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Heart Disease</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Stroke</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>High blood pressure</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Seizures</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Cholesterol</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Thyroid Disease</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Kidney Disease</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Mental Stress</td> <td></td> <td></td> <td></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 TB 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>		Grandfather	Father	Mother	Sister	Brother	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 TB test	_____	Last PSA test (men)	_____	Last PAP (women)	_____	Last Mammogram	_____	Last Bone Density	_____	Last Colonoscopy	_____
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