

McLaren Print System Order

Order No: 5749
 Order Date: 2014-09-12
 User: Linda Evans

Ship Location: McLaren Flint Community Medical Center
 1314 S. Linden Rd. Suite C
 Flint, MI

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

Order Total Price: 50.00

Form Number: MM-3380
 Form 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

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, motorcyclist, 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? b) Has anyone ever: - hit you? - insulted you or put you down? - threatened you? - harassed you, upset you? c) If you answered "yes" to any part of number 6, would you like help dealing with this situation? 7. Do you take safety precautions with firearms in the home? 8. Do you use sunscreen regularly?</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;"> <tr> <td></td> <td>Yes</td> <td>No</td> </tr> <tr> <td>Diabetes</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Cancer</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Heart Disease</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Stroke</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>High blood pressure</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Seizures</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Alzheimer</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Thyroid Disease</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Kidney Disease</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Mental illness</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table> <p>Please indicate the date of your:</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 PEP (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	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	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 PEP (women)	_____	Last Mammogram	_____	Last Bone Density	_____	Last Colonoscopy	_____
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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 week

Recreational Drugs yes no, if yes, what? _____ How much? _____ per day x _____ per week

Coffee yes no, if yes, amount _____ amount _____ per day _____ per week

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 DIRECTIVES: 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. staff use

(SEE REVERSE)