

## McLaren Print System Order

Order No: 5777  
 Order Date: 2014-09-15  
 User: Melissa Hayes  
 Phone: 989-779-5624

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: 5.38

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><b>MEDICATIONS</b> (including over-the-counter medications, herbal supplements)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>MEDICAL PROBLEMS</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>PREVIOUS HOSPITALIZATIONS/SURGERIES/BLOOD TRANSFUSIONS</b>                  (date, reason, hospital/physician)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>SAFETY:</b></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 &amp; 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?                  - forced sex upon you?                  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><b>ALLERGIES:</b></p> <p>_____</p> <p>_____</p> <p>Latex/rape allergy <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p><b>FAMILY HISTORY</b>                  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

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)