

**McLaren Print System Order**

**Order No: 8158 Reprint Previous Order No: 5452**  
**Order Date: 2015-01-12**  
**User: Jean OHalloran**  
**Phone: 248-969-7354**

**Ship Location: McLaren Oakland Oxford Family Medicine**  
**385 N. Lapeer Road**  
**Oxford, MI 48371**

**Forms**

**Quantity: 500**  
**Paragon Dept No: 73600**  
**Dept Name: Oxford Family Medicine**  
**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><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>  <small>(Date, reason, Hospital/Physician)</small></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? <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><b>ALLERGIES:</b></p> <p>_____</p> <p>_____</p> <p>Latex/tape allergy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>FAMILY HISTORY</b>  <small>If any of these relatives have had any of these conditions please check the appropriate box</small></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> <td>Spouse</td> </tr> <tr> <td>Diabetes</td> <td></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> <td></td> </tr> <tr> <td>Heart Disease</td> <td></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> <td></td> </tr> <tr> <td>High blood pressure</td> <td></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> <td></td> </tr> <tr> <td>Cholesterol</td> <td></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> <td></td> </tr> <tr> <td>Kidney Disease</td> <td></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> <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 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>		Grandfather	Father	Mother	Sister	Brother	Spouse	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 PEP (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

**DIRECTIVE:** Would you like information on Advance Directives?  Yes  No Info given: L. (self use)

(SEE REVERSE)