McLaren Print System Order

Order No: 9933 Reprint Previous Order No: 6259
Order Date: 2015-03-19
User: Dawn McPherson
Phone: 586-226-3500

Ship Location: McLaren Macomb Int. Med. Health / Dawn McPherson
37399 Garfield - Suite 106
Clinton Township, Mi 48036

Forms
Quantity: 100
Paragon Dept No: 71650
Dept Name: MMG - Mclaren Macomb Internal Medicine and Health
Company Number: 810

Order Total Price: 0.00

Item Number: MM-3380-M
Item Description: Adult Patient History
Revision Date: 10/2014
Print: 2 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish:
Drill: None
Misc Info:


McLaren Macomb
ADULT PATIENT HISTORY

Patient Name: ____ Date: ____ Sex: ❑ M ❑ F Birthdate ____

MEDICATIONS (including over-the-counter medications, herbal supplements)

ALLERGIES:

Latex/tape allergy ❑ Yes ❑ No

MEDICAL PROBLEMS

FAMILY HISTORY
If any of these relatives have had any of these conditions, please check the appropriate box

Diabetes
Cancer
Heart Disease
Stroke
High blood pressure
Seizures
Glaucoma
Thyroid Disease
Kidney Disease
Mental Illness

PREVIOUS HOSPITALIZATIONS/SURGERIES/BLOOD TRANSFUSIONS
(date, reason, hospital/physician)

SAFETY:
1. Have you fallen in the last year? ❑ Yes ❑ No
2. Do you buckle your safety belt when driving or riding? ❑ Yes ❑ No
3. Do you wear a helmet when riding a bicycle, motorcycle, etc. ❑ Yes ❑ No
4. Do you have current & operational smoke detectors and carbon monoxide detectors? ❑ Yes ❑ No
5. Do you have an updated First Aid Kit in your home? ❑ Yes ❑ No
6. a) Do you feel unsafe at home? ❑ Yes ❑ No
   b) Has anyone ever
   - hit you? ❑ Yes ❑ No
   - insulted you or put you down? ❑ Yes ❑ No
   - threatened you? ❑ Yes ❑ No
   - forced sex upon you? ❑ Yes ❑ No
   c) If you answered "yes" to any part of number 6, would you like help dealing with this situation? ❑ Yes ❑ No
7. Do you take safety precautions with firearms in the home? ❑ Yes ❑ No
8. Do you use sunscreen regularly? ❑ Yes ❑ No

Please indicate the date of your:
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

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
Caffeine ❑ yes ❑ no If yes, source ____ amount ____ per day
Exercise ❑ yes ❑ no If yes, specify type ____ How often? ____
Occupation: ____ Contact with chemicals, lead, 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 ❑ (staff use)

(SEE REVERSE)