McLaren Medical Group

ANNUAL ADULT PATIENT HISTORY UPDATE

Patient Name: ______________________ Date: _____________ Sex: ☐M ☐F Birthdate: ____________

MEDICATIONS

Any new medications in the past year? ☐ **No**

Include over-the-counter medications, herbal supplements

1)	5)
2)	6)
3)	7)
4)	8)

SPECIALISTS

Are you seeing any specialists? ☐ **No**

List their names and city

1)
2)
3)
4)

ALLERGIES ☐ None

New allergies

HOSPITALIZATIONS/SURGERIES/BLOOD TRANSFUSIONS

Any new in the past year? (date, reason, hospital, physician)

1)
2)
3)

FAMILY HISTORY ☐ No Change

Any changes to health conditions of family in the past year?

List condition and check relationship	Mother	Father	Siblings	Grandparents

SOCIAL HISTORY

Tobacco use (smoke or chew): ☐ Yes ☐ No ..... If yes, what?________________ How much?_______per day x _____years

If no, have you in the past? ☐ Yes ☐ No

Alcohol use: ☐ Yes ☐ No .... If yes, what?________________ How much?_______per day ______x per wk

Recreational Drugs: ☐ Yes ☐ No....................... If yes, what?________________ How much?_______per day ______x per wk

Caffeine: ☐ Yes ☐ No .... If yes, what?________________ Amount?_________per day

Exercise: ☐ Yes ☐ No....................................... If yes, type? ________________ How often?______________________

Occupation: __________________________ Contact with chemicals, lead, excessive noise or blood/body fluids at work: ☐ Yes ☐ No (circle those applicable)

SAFETY: Do you feel safe at home? ❑ YES ❑ NO - Have you fallen in the last year? ❑ YES ❑ NO

Has any one ever - Hit you? ❑ YES ❑ NO - Insulted you or put you down? ❑ YES ❑ NO

- Threatened you? ❑ YES ❑ NO - Forced sex upon you? ❑ YES ❑ NO

If you answered "yes" to any part, would you like help dealing with this situation? ❑ YES ❑ NO

DEPRESSION (Check box if any time in the last 2 weeks you have experienced any of the following.)

☐ Little interest or pleasure in doing things?
☐ Trouble falling or staying asleep, or sleeping too much?
☐ Feeling down, depressed, or hopeless?
☐ Feeling bad about yourself or that you are a failure or have let yourself or your family down?
☐ Feeling tired or having little energy?
☐ Trouble concentrating on things, such as reading the newspaper or watching television?
☐ Poor appetite or overeating?
☐ Thoughts that you would be better off dead or thoughts of hurting yourself in some way?
☐ Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual?

Please Sign Below

_______________________________ _______________________ _______________

Patient (or Personal Representative) Relationship to Patient Date

_______________________________ _______________

Physician Date/Time