McLaren Macomb
ADULT PATIENT HISTORY

Patient Name: _____ Date: _____ Sex Assigned at Birth: ❑ M ❑ F Birthdate: _____

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

_____

_____

_____

MEDICAL PROBLEMS

_____

_____

_____

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 safe 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
	If you answered "yes" to any part of number 6, would you like help dealing with this situation?	❑ Yes	❑ No
7.	Do you keep firearms in the home?	❑ Yes	❑ No
7a.	If you answered "yes" to number 7, do you take safety precautions with firearms in the home?	❑ Yes	❑ No
8.	Do you use sunscreen regularly?	❑ Yes	❑ No

ALLERGIES:

_____

_____

_____

Latex/tape allergy ❑ Yes ❑ No

FAMILY HISTORY

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

	Father	Mother	Grandparents	Sister/Brother
Diabetes				
Cancer				
List Type(s) _____				
_____				
Heart Disease				
Stroke				
High blood pressure				
Seizures				
Glaucoma				
Thyroid Disease				
Kidney Disease				
Mental Illness				

Please indicate the date of your:

Last eye exam	
Last dental exam	
Last PSA test (men)	
Last PAP (women)	
Last Mammogram	
Last Bone Density	
Last Colonoscopy	

SOCIAL HISTORY

Tobacco use *(smoke, chew, or vape):* ❑ yes ❑ no If yes, what?_____ If no, have you in the past? ❑ yes ❑ no
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)

McLaren Medical Group

MEDICAL HISTORY

(Check all that apply)

Patient Name: _____ Birthdate: _____

GENERAL:
❑ fever ❑ chills ❑ sweats ❑ fatigue
❑ sleeplessness ❑ headaches ❑ dizziness
❑ weakness ❑ **loss of appetite**
❑ **weight loss/gain** ❑ **eating problems**

EYES:
❑ drainage ❑ redness ❑ itching
❑ blurring ❑ double vision

EARS, NOSE, THROAT, MOUTH:
❑ pain/pressure (areas) _____
❑ congestion/draining (areas) _____
❑ sneezing ❑ decreased hearing
❑ bad breath ❑ frequent nose bleeds
❑ problem with teeth/gums ❑ hoarseness

RESPIRATORY:
❑ shortness of breath ❑ cough
❑ wheezing ❑ blood in sputum
❑ congestion/heaviness in chest
❑ asthma ❑ tuberculosis

CARDIOVASCULAR:
❑ high blood pressure
❑ chest pain/pressure ❑ irregular/rapid beat
❑ jaw/shoulder/arm pain
❑ excessive sweating ❑ poor coloring
❑ swelling/fluid retention ❑ rheumatic fever
❑ varicose veins/phlebitis

GASTROINTESTINAL:
❑ **stomach problems**
❑ **indigestion/heartburn** ❑ **nausea** ❑ **vomiting**
❑ gas ❑ **diarrhea** ❑ **constipation**
❑ blood in stools ❑ blood in vomitus
❑ hemorrhoids ❑ pain
❑ rectal bleeding ❑ **change in bowel habits**
❑ gallbladder disease ❑ hepatitis
❑ special diet

GENITOURINARY:
❑ kidney/bladder problems
❑ burning/painful urination ❑ frequency
❑ night urination ❑ blood in urine
❑ genital sores ❑ vaginal/penile discharge
❑ pelvic pain ❑ itching ❑ bleeding
❑ prostate disease
❑ perform testicular self exam

MUSCULOSKELETAL:
❑ body ache ❑ stiffness (area) _____
❑ swelling ❑ joint pain (area) _____
❑ warmth ❑ arthritis/gout ❑ difficulty walking
❑ Walker/Cane ❑ Wheelchair

SKIN and/or BREAST:
❑ wounds (area) _____
❑ sores (area) _____
❑ dryness ❑ itching ❑ rashes
❑ discoloration ❑ tightening ❑ bruise easily
❑ perform breast self exam

NEUROLOGICAL:
❑ tingling (area) _____
❑ numbness ❑ paralysis
❑ convulsions/seizures

PSYCHIATRIC:
❑ stress ❑ anxiety ❑ agitation ❑ memory loss
❑ 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?

ENDOCRINE:
❑ thyroid trouble ❑ heat or cold intolerance
❑ excessive sweating ❑ thirst ❑ hunger ❑ **diabetes**

HEMATOLOGIC/LYMPHATIC:
❑ swollen glands ❑ tenderness of glands ❑ **anemia**

ALLERGIC/IMMUNOLOGIC:
❑ respiratory distress ❑ hives ❑ itching
❑ difficulty swallowing ❑ swelling
❑ hay fever

REPRODUCTIVE HEALTH:
❑ suspected pregnancy
❑ currently sexually active
❑ condom use
❑ history of sexually transmitted disease
❑ sexual problems

Pregnancies _____ Live Births _____ Abortions _____
Miscarriages _____ Periods: Age Started: ____ Age Stopped: _____
Last Menstrual Period Date _____

Signature: _____ Relationship to patient: _____ Date: _____

OFFICE USE ONLY

Bold print in medical history may indicate dietician/nutritional assessment is required.

Barriers to Communication: ❑ No ❑ Yes, specify: _____

Language Preference for Healthcare: ❑ English ❑ Other, specify: _____

Provider's Signature: _____ Date/Time: _____