

McLaren Print System Order

Order No: 75629 Reprint Previous Order No: 5452
 Order Date: 2023-03-01
 User: Leah Blair
 Phone: 9898263271

Ship Location: Primary Care Att Beth
 2990 Campbell Rd
 Rose City, MI 48654

Forms

Quantity: 100
 Paragon Dept No: 69260
 Dept Name: Primary Care
 Company Number: 810

Order Total Price: 0.00

Item Number: MM-3380
 Item Description: Adult Patient History
 Revision Date: 10/2018
 Print:
 Paper:
 Size:
 Fold:
 Finish:
 Drill:
 Misc Info:

McLaren Medical Group
ADULT PATIENT HISTORY

Patient Name: _____ Date: _____ Sex: M F Birthdate: _____

<p>MEDICATIONS (including over-the-counter medications, herbal supplements)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>MEDICAL PROBLEMS</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>PREVIOUS HOSPITALIZATIONS/SURGERIES/BLOOD TRANSFUSIONS <small>(Date, Reason, Hospital/Physician)</small></p> <p>_____</p> <p>_____</p> <p>SAFETY:</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 & 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. <input type="checkbox"/> No <input type="checkbox"/> Yes Do you feel safe at home? <small>to/has anyone ever</small></p> <p style="margin-left: 20px;">- hit you? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="margin-left: 20px;">- assaulted you or put you down? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="margin-left: 20px;">- threatened you? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="margin-left: 20px;">- forced sex upon you? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="margin-left: 20px;">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 keep firearms in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. If you answered "yes" to number 7, do you take safety precautions with firearms in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Do you use sunscreen regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>ALLERGIES:</p> <p>_____</p> <p>_____</p> <p>Latex/tape allergy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>FAMILY HISTORY <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>Grandmother</td> </tr> <tr> <td>Diabetes</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Cancer</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Let Type(s)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Heart Disease</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Stroke</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>High blood pressure</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Seizures</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Gout/rheum.</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Thyroid Disease</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Kidney Disease</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Mental Stress</td> <td></td> <td></td> <td></td> <td></td> </tr> </table> <p>Please indicate the date of your:</p> <p>Last Tetanus shot _____</p> <p>Last Pneumonia shot _____</p> <p>Last MMR shot _____</p> <p>Last Hepatitis B shot _____</p> <p>Last eye exam _____</p> <p>Last dental exam _____</p> <p>Last TB test _____</p> <p>Last PSA test (men) _____</p> <p>Last PAP (women) _____</p> <p>Last Mammogram _____</p> <p>Last Bone Density _____</p> <p>Last Colonoscopy _____</p>		Grandfather	Father	Mother	Grandmother	Diabetes					Cancer					Let Type(s)					Heart Disease					Stroke					High blood pressure					Seizures					Gout/rheum.					Thyroid Disease					Kidney Disease					Mental Stress				
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SOCIAL HISTORY

Tobacco use (smoker or chaser) 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

Coffee Yes No If yes, amount _____ per day

Exercise Yes No If yes, specify type _____ How often? _____

Occupation _____ Contact with chemicals, heat, explosive noise or blood/body fluids at work? Yes No
(Circle those appropriate)

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

Would you like information on Advance Directives? Yes No Info given: self other

(SEE REVERSE)