

McLaren Print System Order

Order No: 76820 Reprint Previous Order No: 6259
 Order Date: 2023-04-19
 User: Nicholas Briguglio
 Phone: 5868760596

Ship Location: Wound Treatment Center
 1000 Harrington Blvd
 Mt. Clemens, MI 48043

Forms

Quantity: 500
 Paragon Dept No: 29600
 Dept Name: Wound Treatment Center
 Company Number: 260

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 Macmillan
ADULT PATIENT HISTORY

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

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| <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 (Date, reason, hospital/physician)</p> <p>_____</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. a) Do you feel unsafe at home? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p> If yes, anyone else? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p> - Injured you or put you down? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p> - Threatened you? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p> - Forced sex upon you? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p> 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>ALLERGIES:</p> <p>_____</p> <p>_____</p> <p>Latex/tape allergy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>FAMILY HISTORY (Any of these relatives have had any of these conditions, please check the appropriate box)</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <td></td> <td>Yes</td> <td>No</td> </tr> <tr> <td>Diabetes</td> <td></td> <td></td> </tr> <tr> <td>Cancer</td> <td></td> <td></td> </tr> <tr> <td>Heart Disease</td> <td></td> <td></td> </tr> <tr> <td>Stroke</td> <td></td> <td></td> </tr> <tr> <td>High blood pressure</td> <td></td> <td></td> </tr> <tr> <td>Seizures</td> <td></td> <td></td> </tr> <tr> <td>Alzheimer's</td> <td></td> <td></td> </tr> <tr> <td>Thyroid Disease</td> <td></td> <td></td> </tr> <tr> <td>Kidney Disease</td> <td></td> <td></td> </tr> <tr> <td>Mental illness</td> <td></td> <td></td> </tr> </table> <p>Please indicate the date of your:</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 MRSA 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 TB test</td><td>_____</td></tr> <tr><td>Last PSA test (men)</td><td>_____</td></tr> <tr><td>Last HRP (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> | | Yes | No | Diabetes | | | Cancer | | | Heart Disease | | | Stroke | | | High blood pressure | | | Seizures | | | Alzheimer's | | | Thyroid Disease | | | Kidney Disease | | | Mental illness | | | Last Tetanus Shot | _____ | Last Pneumonia shot | _____ | Last MRSA shot | _____ | Last Hepatitis B shot | _____ | Last eye exam | _____ | Last dental exam | _____ | Last TB test | _____ | Last PSA test (men) | _____ | Last HRP (women) | _____ | Last Mammogram | _____ | Last Bone Density | _____ | Last Colonoscopy | _____ |
| | Yes | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Diabetes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cancer | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Heart Disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Stroke | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| High blood pressure | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Seizures | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Alzheimer's | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Thyroid Disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Kidney Disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mental illness | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Last Tetanus Shot | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Last Pneumonia shot | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Last MRSA shot | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Last Hepatitis B shot | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Last eye exam | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Last dental exam | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Last TB test | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Last PSA test (men) | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Last HRP (women) | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Last Mammogram | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Last Bone Density | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Last Colonoscopy | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>SOCIAL HISTORY</p> <p>Tobacco use (smoked or chewed) <input type="checkbox"/> yes <input type="checkbox"/> no, if yes, what? _____ How much? _____ per day x _____ years</p> <p>Alcohol use <input type="checkbox"/> yes <input type="checkbox"/> no, if yes, what? _____ How much? _____ per day x _____ per week</p> <p>Recreational Drugs <input type="checkbox"/> yes <input type="checkbox"/> no, if yes, what? _____ How much? _____ per day x _____ per week</p> <p>Coffee <input type="checkbox"/> yes <input type="checkbox"/> no, if yes, source _____ amount _____ per day</p> <p>Exercise <input type="checkbox"/> yes <input type="checkbox"/> no, if yes, specify type _____ how often? _____</p> <p>Occupation: _____ Contact with chemicals, heat, excessive noise or blood/body fluids at work: <input type="checkbox"/> yes <input type="checkbox"/> no (circle those applicable)</p> | <p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Would you like information on Advance Directives? <input type="checkbox"/> Yes <input type="checkbox"/> No Info given <input type="checkbox"/> (staff use)</p> <p style="text-align: center;">(SEE REVERSE)</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |