McLaren Business Products

**McLaren Print System Order**

**Order No: 78388**
**Order Date: 2023-07-18**
**User: Kellie Roberts**
**Phone: 5864933655**

**Ship Location: McLaren Macomb Family First**
**36500 Gratiot Ave suite 202**
**Clinton Twp, Michigan 48035**
**Forms**
**Quantity: 1000**
**Paragon Dept No: 58705**
**Dept Name: Mt Clemens Family First**
**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**
**Poster:**
**Misc Info:**

**Spec 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

| | Mother | Father | Sister | Brother |
|---|---|---|---|---|
| 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 with this situation? ❑ Yes ❑ No
7. Any 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 ❑ Quit
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)