McLaren Business Products

McLaren Print System Order

Order No: 78693 Reprint Previous Order No: 5452
Order Date: 2023-08-07
User: Danielle Cahoon
Phone: 810-346-2757

Ship Location: Mclaren Brown City Health Care Center /Danielle Cahoon
7115 Cade Rd
Brown City, MI 48416
Forms
Quantity: 500
Paragon Dept No: 65400
Dept Name: Mclaren Brown City Health Care Center
Company Number: 810

Order Total Price: 0.00

Item Number: MM-3380
Item Description: Adult Patient History
Revision Date: 10/2018
Print: 2 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish:
Drill: None
Misc Info:

McLaren Medical Group
ADULT PATIENT HISTORY

Patient Name: _____ Date: _____ Sex: ❑ 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	Brother(s)	Sister(s)	Children
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 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? _____ 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)