

**McLaren Print System Order**

Order No: 80426 Reprint Previous Order No: 6259  
 Order Date: 2023-10-12  
 User: Nicholas Briguglio  
 Phone: 5868760596

Ship Location: **MULTISPECIALTY CLINIC**  
 36500 Gratiot Suite 102  
 Clinton Twp, MI 48043

**Forms**

Quantity: 500  
 Paragon Dept No: 29070  
 Dept Name: MULTISPECIALTY CLINIC  
 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 Macomb  
**ADULT PATIENT HISTORY**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Sex:  M  F Birthdate: \_\_\_\_\_

<p><b>MEDICATIONS</b> (including over-the-counter medications, herbal supplements)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>MEDICAL PROBLEMS</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>PREVIOUS HOSPITALIZATIONS/SURGERIES/BLOOD TRANSFUSIONS</b>                  (Date, reason, hospital/physician)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>SAFETY:</b></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 &amp; 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?                  to have anyone enter <input type="checkbox"/> Yes <input type="checkbox"/> No                  - if you? <input type="checkbox"/> Yes <input type="checkbox"/> No                  - insulted you or put you down? <input type="checkbox"/> Yes <input type="checkbox"/> No                  - threatened you? <input type="checkbox"/> Yes <input type="checkbox"/> No                  - forced sex upon you? <input type="checkbox"/> Yes <input type="checkbox"/> No                  (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><b>ALLERGIES:</b></p> <p>_____</p> <p>_____</p> <p>Latex/tape allergy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>FAMILY HISTORY</b>                  (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;"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <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</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> </tbody> </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 HPIV (women) _____</p> <p>Last Mammogram _____</p> <p>Last Bone Density _____</p> <p>Last Colonoscopy _____</p>		Yes	No	Diabetes			Cancer			Heart Disease			Stroke			High blood pressure			Seizures			Alzheimer			Thyroid Disease			Kidney Disease			Mental illness		
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**SOCIAL HISTORY**

Tobacco use (smoked or chewed)  yes  no if yes, what? \_\_\_\_\_ 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, source \_\_\_\_\_ amount \_\_\_\_\_ per day

Exercise  yes  no if yes, specify type \_\_\_\_\_ How often? \_\_\_\_\_

Occupation: \_\_\_\_\_ Contact with chemicals, heat, 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)