McLaren Print System Order

Order No: 81313 Reprint Previous Order No: 5452
Order Date: 2023-11-29
User: Jean OHalloran
Phone: 248-969-7354

Ship Location: **McLaren Oakland Oxford Family Medicine**
385 N. Lapeer Road
Oxford, MI 48371
Forms
Quantity: 100
Paragon Dept No: 73600
Dept Name: Oxford Family Medicine
Company Number: 810

Order Total Price: 4.48

Item Number: MM-3380
Item Description: Adult Patient History
Revision Date: 11/2023
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 Assigned at Birth: ❑ 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	Grandparents	Sister/Brother
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 eye exam	
Last dental exam	
Last PSA test (men)	
Last PAP (women)	
Last Mammogram	
Last Bone Density	
Last Colonoscopy	

SOCIAL HISTORY

Tobacco use *(smoke, chew, or vape)*: ❑ 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