McLaren Business Products

McLaren Print System Order

Order No: 82351 Reprint Previous Order No: 6259
Order Date: 2024-01-15
User: teresa wyrwicz
Phone: 586-233-5554

Ship Location: 21510 Harrington ste 203

Clinton Twp , MI 48036
Forms
Quantity: 100
Paragon Dept No: 52066
Dept Name: Pain Management
Company Number: 260

Order Total Price: 4.48

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 _____

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

	Father	Mother	Brother	Sister
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 dealing with this situation? ❑ Yes ❑ No
7. Do you take safety 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 ❑ ❑ ❑ ❑
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)