

McLaren Print System Order

Order No: 82590 Reprint Previous Order No: 6259
 Order Date: 2024-01-24
 User: Nicholas Briguglio
 Phone: 5868760596

Ship Location: Jenny Kasprzyk
 1030 Harrington Suite 302B
 Mt. Clemens, MI 48043

Forms

Quantity: 100
 Paragon Dept No: 29800
 Dept Name: Bariatrics
 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 Macmillan
ADULT PATIENT HISTORY

Patient Name: _____ Date: _____ Sex: M F Birthdate: _____

<p>MEDICATIONS (including over-the-counter medications, herbal supplements)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>MEDICAL PROBLEMS</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>PREVIOUS HOSPITALIZATIONS/SURGERIES/BLOOD TRANSFUSIONS <small>(Date, reason, hospital/physician)</small></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>SAFETY:</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 & 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? <small>to have anyone enter</small> <input type="checkbox"/> Yes <input type="checkbox"/> No <small>if you?</small> <input type="checkbox"/> Yes <input type="checkbox"/> No <small>insulted you or put you down?</small> <input type="checkbox"/> Yes <input type="checkbox"/> No <small>threatened you?</small> <input type="checkbox"/> Yes <input type="checkbox"/> No <small>forced sex upon you?</small> <input type="checkbox"/> Yes <input type="checkbox"/> No <small>if you answered "yes" to any part of number 6, would you like help dealing with this situation?</small> <input type="checkbox"/> Yes <input type="checkbox"/> No b) Do you take safety precautions with firearms in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No c) Do you use sunscreen regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>SOCIAL HISTORY</p> <p>Tobacco use (smoked or chewed) <input type="checkbox"/> yes <input type="checkbox"/> no if yes, what? _____ How much? _____ per day x _____ years</p> <p>Alcohol use <input type="checkbox"/> yes <input type="checkbox"/> no if yes, what? _____ How much? _____ per day x _____ per week</p> <p>Recreational Drugs <input type="checkbox"/> yes <input type="checkbox"/> no if yes, what? _____ How much? _____ per day _____ x per week</p> <p>Coffee <input type="checkbox"/> yes <input type="checkbox"/> no if yes, source _____ amount _____ per day</p> <p>Exercise <input type="checkbox"/> yes <input type="checkbox"/> no if yes, specify type _____ How often? _____</p> <p>Occupation: _____ Contact with chemicals, heat, excessive noise or blood/body fluids at work: <input type="checkbox"/> yes <input type="checkbox"/> no (circle those applicable)</p>	<p>ALLERGIES:</p> <p>_____</p> <p>_____</p> <p>Latex/tape allergy <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>FAMILY HISTORY <small>Any of these relatives have had any of these conditions, please check the appropriate box</small></p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <td></td> <td>Yes</td> <td>No</td> </tr> <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's</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> </table> <p>Please indicate the date of your:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>Last Tetanus shot</td> <td>_____</td> </tr> <tr> <td>Last Pneumonia shot</td> <td>_____</td> </tr> <tr> <td>Last MMR shot</td> <td>_____</td> </tr> <tr> <td>Last Hepatitis B shot</td> <td>_____</td> </tr> <tr> <td>Last eye exam</td> <td>_____</td> </tr> <tr> <td>Last dental exam</td> <td>_____</td> </tr> <tr> <td>Last TB test</td> <td>_____</td> </tr> <tr> <td>Last PSA test (men)</td> <td>_____</td> </tr> <tr> <td>Last HPIV (women)</td> <td>_____</td> </tr> <tr> <td>Last Mammogram</td> <td>_____</td> </tr> <tr> <td>Last Bone Density</td> <td>_____</td> </tr> <tr> <td>Last Colonoscopy</td> <td>_____</td> </tr> </table>		Yes	No	Diabetes			Cancer			Heart Disease			Stroke			High blood pressure			Seizures			Alzheimer's			Thyroid Disease			Kidney Disease			Mental illness			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 HPIV (women)	_____	Last Mammogram	_____	Last Bone Density	_____	Last Colonoscopy	_____
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ADVANCE 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)