McLaren Business Products

McLaren Print System Order

Order No: 83322 Reprint Previous Order No: 5452
Order Date: 2024-02-21
User: Angie Claerhout
Phone: 9896673420

Ship Location: Bay Orthopedic Surgery
4 Columbus Ave Suite 160
Bay City, Michigan 48708
Forms
Quantity: 500
Paragon Dept No: 51535
Dept Name: McLaren Bay Orthopedic Surgery
Company Number: 810

Order Total Price: 22.40

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