

McLaren Print System Order**Order No: 83546 Reprint Previous Order No: 5452****Order Date: 2024-03-04****User: LeeAnna Robinson****Phone: 989-956-4100****Ship Location: Heart Center ATTN Teresa
5115 E Pickard Street
Mt Pleasant, Michigan 48858****Forms****Quantity: 500****Paragon Dept No: 50644****Dept Name: Heart Center****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)