

**McLaren Print System Order****Order No: 83971 Reprint Previous Order No: 5452****Order Date: 2024-03-22****User: Mary Bitzer****Phone: 18103421711****Ship Location: McLaren Fenton Family Medicine / ATTN Mary Bitzer  
17200 Silver Parkway Suite 1  
Fenton, MI 48430****Forms****Quantity: 1000****Paragon Dept No: 50022****Dept Name: McLaren Fenton Family Medicine****Company Number: 810****Order Total Price: 41.00****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)