

McLaren Print System Order**Order No: 84562 Reprint Previous Order No: 5452****Order Date: 2024-04-15****User: Jennifer Keeton****Phone: 810-385-6370****Ship Location: McLaren Fort Gratiot Internal Med
5979 Lakeshore Road
Fort Gratiot , Michigan 48059****Forms****Quantity: 500****Paragon Dept No: 58014****Dept Name: McLaren Fort Gratiot Internal Med****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)