

**McLaren Print System Order****Order No: 84726 Reprint Previous Order No: 5452****Order Date: 2024-04-19****User: Kristal Johnson****Phone: 810-487-3601****Ship Location: Grand Blanc CMC  
2313 E Hill Rd  
Grand Blanc, MI 48439****Forms****Quantity: 1000****Paragon Dept No: 50015****Dept Name: Grand Blanc CMC****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)

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**MEDICAL PROBLEMS**

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**PREVIOUS HOSPITALIZATIONS/SURGERIES/BLOOD TRANSFUSIONS**  
*(date, reason, hospital/physician)*

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**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:**

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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)