

McLaren Print System Order**Order No: 85107 Reprint Previous Order No: 5452****Order Date: 2024-04-30****User: Kristal Johnson****Phone: 810-487-3601****Ship Location: Davison CMC
10090 E Lippincott Blvd.
Davison, MI 48423****Forms****Quantity: 1000****Paragon Dept No: 50002****Dept Name: Davison 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)

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)