

McLaren Print System Order**Order No: 86007 Reprint Previous Order No: 5452****Order Date: 2024-06-06****User: Doris Adair****Phone: 810-455-0284****Ship Location: McLaren-Port Huron Urology Associates; Attn: Doris
1037 Water, Street, Suite 1
Port Huron, MI 48060****Forms****Quantity: 1000****Paragon Dept No: 17805****Dept Name: MMG Port Huron****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)