

McLaren Print System Order

Order No: 86117  
Order Date: 2024-06-11  
User: Denise Maginity  
Phone: 810-342-5463

Ship Location: BARIATRIC & METABOLIC INSTITUTE/BEECH HILL CENTRE  
G-3200 Beecher Road, MBI  
Flint, MI 48532

Forms

Quantity: 100  
Paragon Dept No: 36810  
Dept Name: BARIATRIC & METABOLIC INSTITUTE  
Company Number: 60

Order Total Price: 32.60

Item Number: M-5138  
Item Description: Review of Systems  
Revision Date: 5/2012  
Print: 1 sided black and white  
Paper: 20# White Text  
Size: 8.5 x 11  
Fold:  
Finish: Staple (Upper Left)  
Drill: 5 Hole Top  
Poster:  
Misc Info: 6 page, 1-sided print only, stapled and 5 hole top punch

McLaren Bariatric and Metabolic Institute  
FLINT, MICHIGAN

**REVIEW OF SYSTEMS**

Patient Name \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  
 Referring Physician: \_\_\_\_\_ Gender (please circle): Male / Female

Maximum Weight: \_\_\_\_\_ Maximum Weight Loss: \_\_\_\_\_ Minimum Adult Weight: \_\_\_\_\_  
 Years Overweight: \_\_\_\_\_ Years over 100lbs Overweight? \_\_\_\_\_

Hospitalizations: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Past Surgeries: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PLEASE ANSWER THE FOLLOWING QUESTIONS**

Do you have any problems with anesthesia?  Yes  No  
 If yes, what problem(s) did you experience? \_\_\_\_\_

Do you smoke or use tobacco?  Yes  No  
 If yes, how much? \_\_\_\_\_ How long? \_\_\_\_\_

Do you have a history of smoking?  Yes  No  
 If yes, how much? \_\_\_\_\_ How long did you smoke? \_\_\_\_\_ When did you quit? \_\_\_\_\_

Do you drink caffeinated beverages (e.g. coffee or cola)?  Yes  No  
 If yes, how much per day? \_\_\_\_\_ What do you drink? \_\_\_\_\_

Do you use any recreational drugs (e.g. marijuana)?  Yes  No  
 If yes, what type? \_\_\_\_\_ How often? \_\_\_\_\_

Do you drink alcohol (e.g. beer, wine, liquor)?  Yes  No  
 If yes, what type? \_\_\_\_\_ How often (week, social, daily)? \_\_\_\_\_

**PHYSICAL ACTIVITY**

Are you in any exercise?  Yes  No  
 If yes, what time? \_\_\_\_\_ How often? \_\_\_\_\_  
 How many minutes do you exercise at one time? \_\_\_\_\_  
 Describe any physical problems that prevent you from exercising: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

REVIEW OF SYSTEMS  140a

Spec Info: