

McLaren Print System Order**Order No: 87750 Reprint Previous Order No: 5452****Order Date: 2024-08-30****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)