McLaren Business Products

**McLaren Print System Order**

**Order No: 89778**
**Order Date: 2024-11-11**
**Order Request Date:**
**User: Denise Papak**
**Phone: 248-969-7354**

**Ship Location: McLaren Oakland Oxford Primary Care**
**385 N Lapeer Rd**
**Oxford, MI 48371**
**Brochures**
**Quantity: 500**
**Paragon Dept No: 73600**
**Dept Name: Oakland Oxford Primary Care**
**Company Number:**

**Order Total Price: 22.40**

**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**
**Poster:**
**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

Spec Info: